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CHANGES IN THE CONNECTICUT HEALTH PLANNING SYSTEM IN 1975:
A CASE STUDY

DAVID T. KAWANISHI

1976

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CHANGES IN THE CONNECTICUT HEALTH PLANNING SYSTEM IN 1975: A CASE STUDY

by

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PREFACE

> . . . do not regard even the perfect hierarchy, the most harmonious organization, as a machine put together out of lifeless units that count for nothing in themselves, but as a living body, formed of parts and animated by organs which possess their own nature and freedom. Every one of them shares in the miracle of life.
> Hermann Hesse in _Magister Ludi_ or _The Glass Bead Game_

Upon arriving in Hartford in early January, 1975, to begin my duties as a part-time staff member for the Committee on Public Health and Safety of the Connecticut General Assembly, I could not have been made more acutely aware of the "living body" of the public health organization of the State of Connecticut. With nothing more in the way of preparation than my high school civics course, and a more or less undisciplined interest in current events, I approached my role as researcher and consultant for the Committee with much trepidation. As my familiarity with people, process, and policy grew, however, I became increasingly fascinated by this body politic and very soon came to appreciate the power and omnipresence of the political system in public health.

The unique opportunity to work as a staff member of a committee of the State Legislature was provided by a program being administered by the Citizens Conference on State Legislatures. Now known as Legis-50, this organization was

conducting a project, funded by the Robert Wood Johnson Foundation, in which the services of professional staff persons were provided to committees of state legislatures dealing with health and medical legislation. Permanent, full time staffing of state legislative committees is almost non-existent and the hope was that by providing such a resource, the quality and effectiveness of state legislative activities could be improved, at least in the health sector. The Connecticut staff was particularly innovative, being composed of two full-time staffers with background in public administration and state legislative activities as well as two part-time staffers, one being a student working toward the degree of Master's in Public Health and the other, myself, being a medical student. The experience was one of mutual education for the staff as well as the committee chairmen, who had not had previous experience working with a full-time staff, as well as for the rest of the committee and everyone else involved in the public aspects of the health and medical system.

Indeed, the early part of 1975 was a period of much activity, confusion, and learning for just about everyone connected with the public facet of the State's health system. For just at the tail end of the 1974 session, the 93rd Congress of the United States had passed the National Health Planning and Resources Development Act of 1974. The conference version of the bill had been approved by the Senate by voice vote on

December 19 and by the House of Representatives on December 20. On January 4, 1975, President Ford signed the bill and the National Health Planning and Resources Development Act of 1974 became Public Law 93-641, with to say the least, a minimum of fanfare.

With its passage, this bill created a federal mandate for change of the health planning system in each of the 50 states. To follow the implementation of this law seemed a logical way to familiarize myself both with the existing organization of health planning in Connecticut as well as with the nature of policy process and content in health planning.

The thesis proposal which prompted this essay is presented in Appendix A. Documentation in this type of pursuit is often difficult, if not impossible. Many sources wish to remain anonymous. On the other hand, knowledge or expertise in political pursuits such as those dealt with here seems to rest with those who understand the dynamics of interpersonal and power relationships. And documentation of the existence and nature of influence is most difficult, independent of the availability of "sources." But though it was tempting, I did not wish to present a purely schematic description of the various organizations and their bureaucratic interactions either. Political science has apparently attempted to sharpen the distinction between policy process and policy content. In so doing, much has been made of the relative merits of focusing

attention on the one or the other.[1] But in undertaking this investigation, it became clear that only a more synthetic endeavor would yield any insights of value. Both the way in which policy was formed and implemented, as well as the issues and specific ideas of the policy were intrinsic to understanding the outcome. Therefore, the primary endeavor here is to describe as accurately, and with as much insight as disciplined thought will allow, the specific sequence of events which changed the health planning system in the State of Connecticut in 1975.

Though it is hoped that the utility of such a case study will speak for itself, the goal of this essay is twofold. The first is, insofar as it is being submitted in partial fulfillment of the degree of Doctor of Medicine, to cause the author to approach the public and political aspects of the health system with the scholarly discipline of years of formal training and to identify what, if anything, is worthy of recognition. The second goal is to transmit such in a meaningful way to the reader. The utility, and elusiveness, of such goals has been addressed by Herbert Kaufman:

> The comparative absence of research on the politics of such a political field as public health, while offering opportunities for fresh investigation, results from the difficulties of gaining access to the full facts. Some observers believe that the realities of politics are too sensitive for any 'insider' to discuss frankly with an 'outsider,' even if the outsider presents credentials as a qualified, discreet, objective, responsible

> researcher. Indeed, so many of the negotiations and settlements are informal and unrecorded that even willing informants could not give an accurate and complete account of them. The 'truth,' therefore, is not accessible to the researcher, and his report is inevitably incomplete and distorted. Hence the dearth of sophisticated studies of politics in this field; those who are sophisticated enough to appreciate the complexities of the subject and the obstacles to the truth do not try to describe it.[2]

Since this comment was made in 1966, however, a great deal has happened. The federal government has increased its activities in the health field, consumer representation has become a catchword, though its meaning is increasingly unclear probably as a result of the lack of knowledge cited by Dr. Kaufman, health care costs have skyrocketed, a manpower shortage has been noted, PSRO's and utilization review boards were created, and Regional Medical Programs and Comprehensive Health Planning were instituted. And now, with Public Law 93-641, having the potential for the most far-reaching changes yet, another focus for politics in the health field has presented itself. An attempt is made here to describe it.

Individuals whose aid was invaluable in this endeavor include Dr. George Silver and Professor John Thompson whose advice and criticisms are largely responsible for the veracity of the observations made herein. The privilege of working and speaking with Dr. Fred Adams, Dr. Fred Hyde, Representative Cohen, Senator Ciarlone and Ed Bradley is in

large measure responsible for any understanding of the forces of influence which may be conveyed to the reader in ths discussion. Finally, the opportunity to have worked with the Citizens Conference, and especially, to have been a colleague of Ron and Jack, to have been a part of their valiant and pioneering efforts to bring scholarship and discipline to the realm of public policy and decision-making, will serve as an inspiration for a lifetime. Certainly, this influence was a large part of the motivation for this essay and it is hoped that at least some sense of the value and necessity of such activities will have been communicated to the reader. Any falsehoods or inadequacies of the essay remain attributable, of course, solely to the author.

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INTRODUCTION

On December 2, 1974, Senator Edward M. Kennedy (D., Mass.) delivered an address to the medical community in Harkness Auditorium at the Yale University School of Medicine. His talk was entitled, "Partners or Protagonists--Congress and the Academic Medical Centers," and in it he challenged,

> Academic centers have excelled in basic biomedical research. They have not paid as much attention to, or excelled at health services and health policy research. . . . I think we need to develop the same core of excellence in this nation for basic health services and policy research as we have for clinical and biomedical research. I am asking you to study the factors that lead to overuse of hospital beds; to the excessive and unnecessary use of costly diagnostic tests. These are just a few examples. Studying them would not require abandoning your standards of excellence--but only meeting those standards in new disciplines.
>
> The problems of geographic and specialty maldistribution contribute to an increasing public health hazard in this country. . .
>
> I believe the nation's medical centers must help us solve these health delivery problems.[1]

Elsewhere in the speech, the Senator noted the ever-increasing federal contribution to the financing of medical care and, specifically, to the financing of academic medical centers. This relationship, he said, provides the federal government with leverage to promote reform and innovation in the medical centers. The Senator summarized, ". . . so the (medical) centers have their own responsibilities--to the American

people. It is they who are the victims of the health care crisis. It is they who are footing the bill for your activities. They have every right to require your active participation in the development of solutions to these problems."[4] The Senator identified problems in communication as the source of a good deal of the past problems in coordinating medical center interests with legislative activity. Interestingly, the month before, the same Yale medical community had heard similar remarks from the new incoming chief of medicine, Dr. Samuel O. Thier.

Before his selection as Chairman of the Department of Internal Medicine had been announced, Dr. Thier, then of the University of Pennsylvania School of Medicine, made a very rousing presentation of his analysis of the problems being faced by the academic medical centers. Foremost among these, he noted, was the tendency of the medical centers to withdraw from the surrounding community and sequester itself and its interests in the pursuit of pure, scholarly activities, quite apart from the needs of the world around it. This tendency of the scholar-intellectual had been quite well described, he noted, by Hermann Hesse in his novel, _Magister Ludi_. Just as the protagonist of that story had risen to the top of the intellectual community, the Order of Castalia, his lifelong struggle to balance his academic interests with the needs of society compelled him to leave the Order that he might do

something for the people. So, said Dr. Thier, the medical centers such as Yale, must try to address themselves more to the social issues of the times, avoiding the tendency toward isolation, in the hopes of averting a more drastic and rending confrontation in the future.

That these two men of such stature, one from within the medical community, the other from without, should find this particular topic so noteworthy seemed to bespeak a rising sense of urgency and stress in the relationship between the academic medical community and the rest of American society. Rosemary Stevens', American Medicine and the Public Interest, amply demonstrates that the winds of change had started to blow long before. [5]

Was there any evidence of stress and impending change in the relationship of medicine to the rest of society in Connecticut? It turned out that the time was ripe for asking such a question. The year 1975 was to be the beginning of a new federal program which shows signs of forming the basis for a very different sort of health system from any the United States has seen before. In terms of attempting to observe first hand, the beginnings of a new orientation and organization in the system, the setting and timing were perfect.

THE NATIONAL HEALTH PLANNING AND RESOURCES DEVELOPMENT ACT OF 1974

Legislative Background

Understanding the changes which took place in Connecticut's health planning system in 1975 requires knowledge of the National Health Planning and Resources Development Act of 1974. Passed by Congress at the end of its 93rd Session, it was signed by President Gerald Ford on January 4, 1975 becoming Public Law 93-641.

As is most Federal legislation, it was the culmination of an extensive series of events, debates, and compromises. Also typical of most Federal legislation, it is only the visible tip of a huge and complex interaction of forces taking place in the nation's health and health planning sector. The dynamics of these changes in the past is well described by Rosemary Stevens in her excellent text, American Medicine and the Public Interest.[6] Her book concludes with discussion of the Congressional focus on cost control which she relates to the unexpectedly high Federal expenditures under the Medicare and Medicaid programs. That both Medicare and Medicaid programs were an attempt to provide increased access to the American medical care system is pertinent to P. L. 93-641, in that many see this law as a preliminary step

to some sort of national health insurance.* Congressional concern for quality of care and the development of American health care resources is also described by Dr. Stevens. These forces saw Congressional action in the form of the Regional Medical Program (RMP) and the development of Comprehensive Health Planning (CHP) to coordinate resource development and planning activities at the community level, respectively. Funding of resource development and planning of sorts, in the form of the Hill-Burton program had been in existence since 1946, of course. Congressional impact also filtered down to the states and communities through the many programs funded in whole or in part under the Public Health Services Act. P.L. 93-641 is an attempt to consolidate these activities as well as pave the way for future federal efforts at improving the American health care delivery system. The essentials of the new law, in fact, are an amalgamation of the old.

The Hospital Survey and Construction Act, P.L. 79-725, commonly known as the Hill-Burton Act, has spent some $4

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*Specifically, it establishes an organizational structure extending from the level of the Department of Health, Education and Welfare all the way down to the community level and charges it with drawing up priorities and plans for the distribution and development of services and resources in the health service industry. It also contains financial incentives to states if they choose to regulate rate increases in the health sector. It seems that reversing the Medicare/Medicaid experience, the federal government is trying to evaluate the health care system and control the expansion of services and resources in anticipation of future attempts to finance that system.

billion on construction and modernization of medical care facilities since 1947.[7] It originally authorized grants to the states for surveying state needs and developing state plans for construction of hospitals and public health facilities and for the actual construction of such facilities. In 1957, this was expanded to include out-patient facilities and rehabilitation facilties. In 1964, it was further amended to include a new category of long-term care facility and added grants for modernization or replacement of facilities. And again, in 1970, it was amended to allow grants for neighborhood health centers, assignment of priority for ghetto and rural communities and for facilities providing comprehensive health care, training in the health or allied health professions, and treatment of alcoholism. Since the start of the loan guarantee program in January, 1972, of the 255 projects assisted since the inception of the program, 244 were for modernization of existing facilities or addition of services such as out-patient facilities and long term care beds to existing facilities. By 1974 the annual value of all health facilities construction in the United States amounted to $4.5 billion, of which grants under the Hill-Burton program accounted for $120 million, or around 2.7% of the total. Though this was a decrease from a high of the 16% contribution to the total in 1960, the program was still considered to have value and was retained as part of the new law in modified form.

The Regional Medical Program did not fare as well, however. This program was established by the Heart Disease, Cancer and Stroke Amendments of 1965, P.L. 89-239.[8] The legislation was intended to respond to the recommendations of the Report of the President's Commission on Heart Disease, Cancer and Stroke published in late 1964. That report called for the establishment of "regional medical complexes" to unite the worlds of research, medical education, and medical care in a coordinated effort to combat the three disease categories. The law which added Title IX to the Public Health Services Act differed from the initial legislation, however, in that it called for "regional cooperative arrangements." This was a result of the fears of private practitioners that the "regional medical complexes" would be dominated by academic medicine and would result in a major redirection of patient referrals. Indeed, both RMP and CHP legislation began with prefaces pledged to noninterfering with existing patterns of practice. (See P.L. 89-239 and 89-749)

In 1970, in addition to extending the program, P.L. 91-515 made some major changes in the focus of the program. It added coverage of kidney diseases to the categorical approach of the original law. But, in addition, it put a new emphasis on primary care and the linking of primary, secondary and tertiary care as well as on regionalization of health care resources and better use of health manpower resources.

This was to prove to be a fatal redirection of the RMP. For as long as it retained a focus on a categorical approach to disease, there was no need for coordination with community health planning programs. Indeed, as far as its original mission of disseminating knowledge to and coordinating the efforts of health care providers, RMP had accomplished a great deal. Notable were its efforts in increasing the number of cardiovascular nurses, emergency medical personnel with better quality and level of training, hypertension screening programs and coronary care monitoring, tissue typing and transplantation facilities and services, and dialysis centers. Roughly $600 million had been invested in RMP since its inception and its successes were seen as relating to the, ". . . structures that were established and the process that has been created."[9] Its failure was seen to be a lack of results comparable to the sum that had been invested. This failure was attributed to the diffuse nature of RMP's efforts. RMP was further criticized as not always addressing priority community problems and needs. In its final report on H.R.16204, the House's pre-conference version of P.L. 93-641, the Committee on Interstate and Foreign Commerce, noted:

> This is not to say that these substantive failures and shortcomings were entirely the fault of RMP. The frequent absence of local plans and specific priorities certainly contributed. Moreover, the national priorities expressed by HEW in this and previous administrations often changed and were inconsistent, and militated against more significant end results and impact by RMP. The failure of the

> Congress in the several extensions of the RMP legislation to provide greater specificity in program objectives may also have contributed in some measure.
>
> Perhaps most fundamental though was the effect of the shift made in 1970 from the original concept of RMP as a disease focused program with primary responsibility for the dissemination of knowledge to health care providers to a concept which was similar to that of CHP (the development of primary ambulatory services, comprehensive services, emergency medical services, and generally the implementation of HEW health priorities.[10]

Here was a program, in summary, which originally was aimed at resources development and was now moving into the realms of planning.

The first Congressional effort to mandate health planning was a modification of the Hill-Burton Act to fund regional health facilities planning agencies in 1964. Realizing that planning for facilities without planning for health manpower needs, health services, and other aspects of the health system would lead to a skew of resources toward development of expensive health facilities, Congress emphasized in the CHP legislation that planning include the totality of the health system as well as pertinent aspects of the environment. But the Comprehensive Health Planning program was also noted to have deficiencies.[11] Established by the Comprehensive Health Planning and Public Health Service Amendments of 1966, P.L. 89-749, it marked only the second Congressional attempt to mandate planning in the health field.

The approach was a three-part structure for health planning. At the state level, grants were authorized for a state comprehensive health planning program. This became section 314(a) of the Public Health Services Act and the state agencies created under it have come to be known as the 314 "A" Agencies. To qualify for such a grant, a state was required to submit a plan which designated a single state agency to administer the state's planning process, established a council to advise the agency, and provided for an annual work program and budget for comprehensive planning. The council had to be broadly representative of public and private health organizations with a consumer majority. At the second level was established grants for up to three quarters of the cost of operating public or non-profit private organizations for the purpose of areawide comprehensive health planning. This became section 314(b) of the Public Health Services Act and the agencies thus funded are known as the 314 "B" agencies. Grants could be awarded only with the approval of the state agency and were to be used to draw up local or areawide plans for developing and/or coordinating services, facilities, and manpower. Finally, grants were authorized for training, studies, and demonstration projects in comprehensive health planning in order to increase the resources of the country needed for the success of the other two parts of the law.

In 1967, modification of the original authority required the state "A" Agency to assist facilities in developing their capital expenditure programs and required that CHP "B" agencies, that were not themselves local government units, should have representation of those interests on their governing boards. Amendments in 1970 required the CHP "B" Agencies to have on their governing boards representation of the interests of hospitals and other health care facilities, physicians, and the general public. Also in 1970, further amendments required that the state planning council should have representatives of RMP and other federal health programs as members. An example of the latter would be any veterans administration hospitals in the state. Furthermore, the CHP "B" agencies were required to assist health care facilities in their area in the development of capital expenditure programs. Applications for grants for health services development were henceforth required to be sent to the appropriate CHP"B" agency for review and comment. Finally, a National Advisory Council on Comprehensive Health Planning Programs was established to advise the Secretary of the Department of Health, Education and Welfare (DHEW),

In a most significant development, section 1122 was added to the Social Security Act in 1972. The new law, P.L. 92-603, provided that health care facilities and HMO's could not be reimbursed under Medicare, Medicaid or the

maternal and child health programs for depreciation, interest or return on equity capital attributable to capital expenditures which were determined by the state CHP "A" agency to be inconsistent with the standards or plans developed by those agencies. An attempt to prevent Medicare and Medicaid from paying for the development of unneeded facilities, it indicates Congressional desire to link health financing to health planning.

By 1974 there were 56 CHP "A" agencies funded at the level of $10 million. In previous years funding had been even less ample, however. Only $7.7 million was spent in 1971 and 1972 in which years 26 agencies received the minimum of $100,000 each. Since this accounted for almost the entire budget of many of these agencies, it implies a staff of less than five people in those states. The nature of the agency varied from state to state such that ten were in combined health and welfare or human resources departments, 24 were in health departments, 18 were in the office of the Governor or state planning office, two were independent agencies, and two were interdepartmental commissions.

Also in 1974, HEW funded 218 CHP "B" agencies covering 79% of the U.S. population. The nature of the agencies was such that 161 were nonprofit private corporations, 16 were economic development districts, 18 were regional planning commissions, eight were councils of government (COG),

and 12 were state assisted local councils. Underfunding and understaffing was again a major problem even though the areawide agencies tended to be funded at a higher per capita rate than the state agency. Indeed, less than 20% of the "B" agencies had a published plan by 1974.[12]

A lack of direction from DHEW was also seen to be a part of the problem with the CHP program and it was not until March of 1973 that HEW first focused the CHP agencies on specific priorities and objectives. These included minimizing wasteful duplication of facilities and unnecessary services, control of costs by improved efficiency, productivity, and preventive health services, and the promotion of competition to improve the consumers choices.

In general, the acknowledged weaknesses of the CHPs were noted to be:

1. too few resources to support the program
2. insufficient staff and volunteer training
3. an uncertain charge in combination with little mandate or power
4. competition with other federally-supported programs.[13]

Here, then, was a planning program that was weak in developing resources.

Among the "other federally-supported programs" were the Experimental Health Services Delivery Systems (EHSDS) developed in 1971 by the now defunct Health Services and Mental

Health Administration. The objective was to test whether a community management system could be used to improve health services delivery. Contracts were awarded to 12 communities throughout the country after an intense competition. Each of these was for the purpose of establishing and operating an autonomous management corporation based on a coalition of providers, payers, politicians, and representatives of the public. The program was entirely conducted under the research authority of section 304 of the Public Health Services Act. Despite the fact that most of the EHSDSs had developed extensive data systems, management, and planning staff and data and had, in several cases begun effective planning, the House Committee on Interstate and Foreign Commerce in 1974 raised the following concerns:

1. the program is a poorly designed experiment in that no baseline studies or data were compiled and no control communities were selected
2. the program never had a legislative authority thereby creating a lack of Congressional oversight, policy direction, and most importantly, Congressional support and interest
3. the programs have not been and lack the capacity to be delivery systems and, as a corollary, do not clearly suggest how they will manage the delivery system of their community
4. the program stands in conflict, both in terms of goals and funds, with the existing RMP and CHP programs.[14]

Essentially, then, the EHSDSs had the wrong sponsor.

It was with this situation in the health planning sector that Congress began the 1973 session. In that year, coincidentally, the RMP, CHP, and Hill-Burton programs were

all up for renewal. They got it, but only for one year, as Congress decided to study the problem with an eye toward developing new legislation.

On February 8, 1974, Senator Edward M. Kennedy introduced S. 2994, known as the National Health Planning and Development Act of 1974. Over in the House, a bill known as the National Health Policy and Health Development Act of 1974, H.R. 12053, sponsored by Congressman William Roy (Dem., Kansas) had been around since December of 1973. Both went through hearings during 1974 and were reported out as S. 2994 and H.R. 16204.

The House Report which accompanied H.R. 16204 reported the following findings:

1. Planning should be done by organizations which represent and incorporate the interests of consumers of health services, providers of the services, and concerned public and private organizations. (The Committee was impressed by the credibility and representative nature of the CHP boards.)
2. In order to be effective, health planning must be adequately financed. (Attention was drawn to the disparity between pay and quality of staff of the well-funded RMP program and that of the poorly funded CHP program.)
3. Effective planning requires a strong emphasis on the implementation of plans and implementation requires that planning agencies have authority with which to implement the plans. (Here the Committee addressed the inability of CHPs to implement programs which they determined were needed as contrasted to RMP success in this area.)
4. The generation of new health resources should be closely tied to health planning.

5. If health planning is to be done, it should be good health planning. (The Committee saw a need to assess the quality of grantees of federal funds.)
6. Effective federal, state and areawide health planning will be possible only if the federal government itself engages in health planning. (In addressing the lack of direction of the CHP program as one of its major flaws, the Committee included a set of national health priorities as part of the legislation and set up a National Council for Health Policy within DHEW charged with making specific recommendations for a national health policy based on the priorities specified by the new law.)
7. If planning is actually to improve people's health, it must not be limited just to planning for medical care. (The Committee saw the need to allow the planning agencies to include personal health education and environmental concerns where relevant to improving the health of the people.)[15]

These comments delineate the major policy issues faced by the legislation and are appropriate for the law as embodied in P.L. 93-641. Quite obviously, the move was to put teeth into the old CHP program.

Some issues of contention included a serious questioning of the wisdom of granting governmental powers to nonprofit corporations. The point was raised that there are no clear-cut methods for the redress of grievances under such a system. Furthermore, undue pressures would be brought to bear on the governors of the various states in their attempts to divide the state into planning areas and select agencies for those areas. And again, there would be no clear-cut system by which those who were not included on the boards of

the new agencies could make their positions known. There was doubt cast on the compatibility of the functions of planning, resource development, and regulation. Planning requires a focus on broad community needs and a different range of skills from resource development efforts. The latter requires a more extensive and detailed knowledge of medical and health care. Finally, regulation requires still a third range of skills and orientation of priorities. Curiously, the most vocal proponent of these views was Paul D. Ward, Executive Director, California Regional Medical Program.[16] Congress had obviously opted for the more pluralistic and comprehensive approach to planning embodied in the former CHP program, at the sacrifice of the above concerns, and the RMP program.

Along a somewhat similar vein were objections raised by the National Association of Counties and the National Governor's Conference. They saw the new legislation as an attempt to bypass state and local government and set up an independent system under the aegis of the Secretary of HEW. The major change effected by these objections was the inclusion of provisions that the new areawide planning agencies could be public regional planning bodies or a single unit of general local government.

The conferees of the House and Senate met to resolve the differences between H.R. 16204 and S. 2994 on December 19,

1974. The changes were mostly technical and of a minor nature such that the Senate approved the conference version on December 19, and the House approved it on December 20. On December 24, S. 2994 was presented to President Ford and was signed into law on January 4, 1975, becoming Public Law 93-641.

The prime mover behind implementation of the new law was to be Eugene Rubel. Formerly Director of the Office of Comprehensive Health Planning in the Health Resources Administration of the DHEW, he was called on to head the new Bureau of Health Planning and Resources Development within HRA. His early comments:

> We are now very definitely intervening in the private practice of medicine and in the organization and operation of health care institutions. . . and the primary reason is dollars. More and more of the federal budget is going toward health care expenditures.
>
> This law is attempting to provide a better management focus for the health industry. It is clearly a step in the direction of national health insurance, and it is an attempt to avoid the mistakes made with Medicare and Medicaid.[17]

And as to what he anticipates as the biggest problem in implementation:

> Figuring out a way to get providers to participate and getting them to gear their own planning to the needs of the community. There's been too much antagonism in the past. . .[18]

It seems that the old CHP organization is being given a new opportunity and a huge responsibility. The early stages of implementation would be a major clue as to the eventual

results of Congressional intent. But as early as May, 1975, only four months into the process, Dr. James H. Sammons, executive vice-president of the AMA, was quoted as saying that this act is, ". . . the single, most potentially destructive piece of medical legislation ever enacted by the Congress."[19]

Public Law 93-641

This Act was considered to be the only major piece of health legislation to be passed by the 93rd Congress. For the many who anticipated some form of national health insurance, it must have been quite a disappointing session. But P.L. 93-641 has the potential to effect, or cause to be effected, very great changes in the American health services system.

It consists of two parts. Title XV, National Health Planning and Development, essentially replaces the old RMP and CHP programs. Title XVI, Health Resources Development, assumes the authority to oversee spending of funds for construction and modification of health care facilities from the old Hill-Burton agencies.

A copy of this extremely complex law is included as Appendix B.

One unique feature of the law is the inclusion of a set of priorities to be considered in the formulation of

national health planning goals and in implementation of the law at the federal, state, and area level. These priority considerations are:

1. The provision of primary care services for medically underserved populations, especially those which are located in rural or economically depressed areas.
2. The development of multi-institutional systems for coordination or consolidation of institutional health services (including obstetric, pediatric, emergency medical, intensive and coronary care, and radiation therapy services).
3. The development of medical group practices (especially those whose services are appropriately coordinated or integrated with institutional health services), health maintenance organizations, and other organized systems for the provision of health care.
4. The training and increased utilization of physician assistants, especially nurse clinicians.
5. The development of multi-institutional arrangements for the sharing of support services necessary to all health service institutions.
6. The promotion of activities to achieve needed improvements in the quality of health services, including needs identified by the review activities of Professional Standards Review Organizations under part B of Title XI of the Social Security Act.
7. The development of health service institutions of the capacity to provide various levels of care (including intensive care, acute general care, and extended care) on a geographically integrated basis.
8. The promotion of activities for the prevention of disease, including studies of nutritional and environmental factors affecting health and the provision of preventive health care services.
9. The adoption of uniform cost accounting, simplified reimbursement, and utilization reporting systems and improved management procedures for health service institutions.

10. The development of effective methods of educating the general public concerning proper personal (including preventive health care and methods for effective use of available health services).

These priorities are remarkable not only in their inclusion in the law, which in itself makes them unique, but also in their content. As noted elsewhere, these clearly delineate extensive federal involvement in America's medical and health care sector. Furthermore, there is not the pledge to "preserve the existing patterns of the private professional practice of medicine. . ." or to not "interfere with the patterns or the methods of financing of patient care or professional practice" as in the CHP and RMP legislation.

Just as remarkable is the system created to attend to these priorities. Essentially, a four-level system is developed which combines the activities of health planning and resources development, and to a limited extent, regulation of some parts of the health care delivery system:[20]

1. At the local level are established Health Service Areas (HSA):

AREA: These areas will encompass populations between 500,000 and 3,000,000. Standard Metropolitan Statistical Area (SMSA) boundaries must not be violated. Waiver of these requirements may be granted by the Secretary.

COMPOSITION: The Agency operating in each area, the Health Systems Agency (HSA), may be either a nonprofit private corporation, a public regional planning body, or a single unit

of general local government if its area of jurisdiction is identical to that of the health service area. The agency board must have been 10 and 30 members which constitute the governing body. It may have more than 30 members in its governing body, however, if the governing body establishes another unit, the executive committee, of not more than 25 members of the governing body and delegates to that committee the authority to take such actions as the governing body is authorized to take. A majority, but less than 60% of both bodies must be consumers. The remainder of the members shall be providers representing:

a. Physicians, dentists, and nurses and other health professions
b. health care institutions
c. health care insurers
d. health professional schools
e. allied health professions

and not less than one third of the provider representatives must be direct providers of health care. Membership must also include public elected officials and other representatives of governmental authorities in the area and representatives of public and private agencies concerned with health. Also, the membership must include a percentage of individuals residing in nonmetropolitan areas within the HSA, the percentage being equal to the percentage of residents of the HSA who live in such areas. A representative from any veterans

administration health care facility in the area and from any health maintenance organizations in the area must also be included in the governing body.

SUBAREA COUNCILS: The HSA may establish subarea advisory councils representing parts of the area to advise the governing body of the agency. The composition of such councils must conform to the above constraints also.

STAFF: The size of the professional staff of the HSA is to be not less than five.

PURPOSE: The functions of this agency are to develop a Health Systems Plan (HSP) which is a statement of goals and an Annual Implementation Plan (AIP) which is a means of attaining those goals.

The ideals to be sought are:

a. Improving the health of residents of the HSA.
b. Increasing accessibility, acceptibility, continuity, and quality of health services.
c. Restraining increases in cost of providing services.
d. Preventing unnecessary duplication of health resources while promoting developing of needed services, manpower, and facilities.

These plans will be based upon the following data to be gathered by the agency:

a. Status of health of residents of its area.
b. Status of health care delivery system and the use of that system.

c. Effect the health care delivery system has on the health of residents.

d. Nature of area's health resources, including health services, manpower, and facilities.

e. Patterns of utilization of resources, and

f. Environmental and occupational exposure factors affecting health.

The HSA must also review and approve or disapprove proposed use of federal funds appropriated under two programs other than the Public Health Services Act, namely, the Community Mental Health Centers Act and the Comprehensive Alcohol Abuse and Alcoholism Prevention Act. This is in addition to the power of review of all proposed use of federal funds appropriated under the Public Health Services Act within the jurisdiction of the HSA, as well as of all proposed use of state funds for similar development, expansion, or support of health resources. The HSA must also make recommendations to the state agency as to the appropriateness of any proposals for new institutional services as well as reviewing at least every five years, all existing services and making similar recommendations as to their continued appropriateness or need. It additionally is authorized to make grants and contracts with entities to assist them in planning and developing projects which are necessary for achieving the health system described in its HSP. Funds for such grants

shall be made from the Area Health Services Development Fund and provided to each HSA at the rate of $1 per capita. Finally, each HSA is instructed to coordinate its activities with each PSRO, model cities, and other general or special purpose planning or administrative agency in its area.

2. State Health Planning and Development Agencies (State Agency) are established to deal with health planning and resources development on a statewide level.

AREA: The area encompassed will be that of the state.

COMPOSITION: The state agency must be an agency of the government of the state with membership to be determined by the governor.

PURPOSE: The specified functions of the state agency are:

a. Plan statewide and implement those part of the state and HSA plans which relate to the state government
b. Be responsible for a preliminary State Health Plan which is to be made up of the HSPs
c. Approve and administer fund appropriations for medical facilities construction or modification. Authorization for such funding is to be granted by issuing "certificates of need." Such need is to be determined under a state Medical Facilities Plan which must be prepared by the state agency and submitted for approval to the SHCC,

and serve as the designated planning agency of the state for the purposes of Section 1122 of the SSA.

d. Investigate the need for new services as proposed by HSAs.

e. Annually investigate and make public its findings concerning health services being offered in the state.

f. Although rate regulation is not mandated, it is encouraged (see Funding).

g. Make findings as to the need for proposed new services with respect to the appropriate HSA recommendations.

h. Periodically, but at least every five years, review all institutional health services and, after considering recommendations of the HSAs as to the continued appropriateness of such services, make public its findings.

PENALTY: If a state does not have a state agency in operation by 1980, the Secretary of HEW may not make any allotment, grant, loan, or loan guarantee, or enter into any contract, under the Public Health Services Act, the Community Mental Health Centers Act, or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of

1970 for the development, expansion, or support of health resources in such state until such time as such an agency is established.

3. A Statewide Health Coordinating Council (SHCC) is established in each state to advise the state agency. In fact, however, its specified functions suggest that its level of authority interposes it somewhere between the Secretary of HEW above and the state agency and HSAs below.

AREA: The SHCC oversees health planning and resource development activities within its state boundaries.

COMPOSITION: The council will have at least 16 members, selected by the governor from a list of five nominees submitted by each of the HSAs. Each HSA will be entitled to the same number of representatives with a minimum of two from each HSA. At least one half of the representatives from each HSA must be a consumer. The governor may additionally appoint other persons such as elected officials and representatives of governmental authorities. Such additional appointees may not exceed 40% of the total membership of the SHCC and a majority of these appointed must be consumers of health care. All told, not less than one third of the providers of health care on the SHCC shall be direct providers of health care:

PURPOSE: The functions of the SHCC are:

a. Review and coordinate each HSP and AIP and report to the Secretary of HEW.

b. Prepare and annually review and revise a state health plan made up of the HSPs and the preliminary state health plan submitted by the state agency.

c. Annually review the budget of each HSA and report comments to the Secretary.

d. Review grant applications from each HSA and report comments to the Secretary.

e. Annually approve or disapprove any state plan and any application submitted to the Secretary as a condition to the receipt of funds under this Act, the Community Mental Health Centers Act, or the Comprehensive Alcohol Abuse, and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970.

f. Approve or disapprove the state medical facilities plan submitted by the state agency.

4. Finally, at the federal level, there is established a National Council on Health Planning and Development.

AREA: This body will be oriented toward health of the nation as a whole.

COMPOSITION: This council will exist as an advisory body to the Secretary within the Department of Health,

Education, and Welfare. It shall have 15 members. Three nonvoting ex officio members are the Chief Medical Director of the Veteran's Administration, the Assistant Secretary for Health and Environment of the Department of Defense, and the Assistant Secretary for Health of the DHEW. Of the rest, at least five shall be nonproviders of health care, no more than three shall be federal officers or employees, at least three shall be members of governing bodies of HSAs, and at least three shall be members of SHCCs. Terms of office are six years and the chairman is selected by the members of the Council from among their number.

PURPOSE: The Council is to make recommendations to the Secretary with respect to:

a. the development of national guidelines under the priorities set forth under this Act

b. the implementation and administration of this part of P.L. 93-641

c. Evaluation of the implication of new medical technology for the organization, delivery, and equitable distribution of health care services.

FUNDING: This legislation authorizes over $1 billion in allocations for implementation over a period of three years. Of this, planning grants for operation expenses to HSAs are authorized as being the lesser of:

a. $0.50 x the HSA population, or

b. $3,750,000

However, an HSA may not receive less than $175,000 annually. The legislation authorizes $60,000,000 for fiscal year ending June 30, 1975, for this purpose and amounts increasing up to $125,000,000 for fiscal year ending June 30, 1977.

Grants to state agencies are authorized to be made at the discretion of the Secretary. This amount is not to exceed 75% of the cost of operation of the state agency in any given year. The law authorized $25,000,000 for fiscal year ending June 30, 1975, $30,000,000 for 1976, and $35,000,000 for 1977, for this purpose.

The law authorizes the Secretary to establish regulations for regulating rates for provision of health care. It allows him to award demonstration grants to no more than six state agencies which make a commitment to carry out rate regulation. Authorized funds are $4,000,000 for fiscal year ending June 30, 1975, $5,000,000 for 1976, and $6,000,000 for 1977.

Under Title XVI of this law, "Resourses Development," allocations are allowed for modernization, conversion, or construction of medical facilities, provided such projects are approved by the state agencies. The law authorizes $125,000,000 to be appropriated for this purpose for fiscal year ending June 30, 1975. See Table 1 for a summary of total authorizations.

Public Law 93-641: New authorizational authority

	FISCAL YEAR			
Planning and regulation:	1975	1976	1977	Totals
Health Systems Agency planning grants	$60	$90	$125	$275
State Health Planning and Development Agency grants	25	30	35	90
Demonstration grants for regulation of rates for health services	4	5	6	15
Centers for Health Planning–grants or contracts	5	8	10	23
Subtotals	$94	$133	$178	$403
Resources development:				
Health facilities construction and modernization allotments and grants**	$125	$130	$135	$390
Health facilities construction and modernization loans and loan guarantees**	*	*	*	*
Development grants for area health services development funds	25	75	120	220
Subtotals	$150	$205	$255	$610
Grand totals	$244	$338	$431	$1,013

*The law authorizes "such amounts as may be necessary." Exact amounts are appropriated by the Congress.

**Formerly the Hill-Burton program.

As of February, 1976, actual Congressional appropriations for health planning and resources development totaled \$98.2 million and for health facilities construction \$138.0 million.[21] Congressional intent that this legislation be successfully implemented was not reflected in its financial support of the program.

Analysis

The background information suggests that this law was primarily an attempt to beef up the old CHP program while accepting many of the principles contained in it. The RMP and EHSDS programs were essentially dropped. The administration of Hill-Burton funds was to be taken over by the state agency of the new law which would be more closely related to the local planning agencies than under the former system.

In terms of subsequent implementation, the following observations are pertinent:

1. The role of the consumer was reaffirmed and augmented.
2. A pluralism of input into the health planning agencies at the local level is mandated.
3. Communitywide planning is sought such that the new law most closely resembles the CHP program while very little of the RMP or EHSDS programs was retained.

4. Integration of planning and resource development is mandated at both the community and state levels and their further integration with regulation is encouraged at the state level.
5. Congressional authorizations suggest a real commitment to the program.
6. Powers specified for the new system include certificate of need authority for allocation of funds for facilities construction or modification in the state agency, review of both proposed and existing facilities for determination of appropriateness and need on an ongoing basis at both area and state level, and power of approval or disapproval for all funds going to health resources development from any programs under the Public Health Services Act, the Community Mental Health Centers Act, or the Comprehensive Alcohol Act and from all state administered programs.
7. The HSAs will have their own resources development fund.
8. The law specifies a specific set of priorities to be sought by the new system. That is, it is a goal-oriented approach with specific ends in mind. An implicit goal not stated in the legislation but acknowledged by many is the attainment in future of some sort of national health insurance.

9. Consistent with the House report emphasizing federal initiative in planning and development, the lines of authority are pretty clearly delineated in a vertical manner from the HSAs upward to the SHCC and then to DHEW. Aside from the certificate of need authority, the position and role of the state agency in this scheme is nebulous.
10. The legislation specifies characteristics of the health service areas such that funding will be adequate to support a staff and such that the units which comprise the areas (SHSAs) will have some known characteristics and can serve as a basis for information and data acquisition and evaluation.

CONNECTICUT'S HEALTH PLANNING SYSTEM

Public Law 93-641 mandated a significant change in the health planning system of Connecticut. Although in many ways, the forces at work within the state and the structure of its health system were just a microcosm reflecting the problems already described at the federal level, there are many features which make Connecticut unique. Understanding of the implementation of a law such as this requires a background understanding of the state.

Connecticut has a population of just over 3,000,000 in an area of about 5,000 square miles.[22] It is divided into 169 towns. It had eight counties until these were legally abolished in 1960. Driving time from one end of the state to the other is around two and one half hours.

Although Connecticut had the highest per capita income of any state in 1973, at $5,938, there is a wide range throughout the state. Considered by town, for example, median income ranges from a low of $7,800 in Union to a high of a median $23,885 for New Canaan. This disparity reflects the distribution of population which ranges from poor rural in the eastern and northeastern parts of the state to affluent suburbia in the southwest. Most of the population is concentrated in a "J" configuration from Hartford in the center of the state southward along the Connecticut River

Valley and in a corridor which angles southwestward along the coast toward New York. The four largest towns are Hartford, Bridgeport, New Haven and Waterbury.

The context of passage of the new law, at the state level, was in many ways parallel to Congressional concerns at the national level. Of major interest and concern was the rising cost of health care services.

In fiscal 1973, Connecticut spent some $1.7 billion on its health care industry, according to a University of Connecticut Health Center Study noted in the Hartford Courant, June 4, 1975.[23] This accounted for 8% of the gross state product. This amount came to $549 per capita, and ranked behind only insurance and manufacturing. Expenditures broke down as follows:

Hospital care	$604 million
Physican services	285 million
Drugs and medications	195 million
Dental services	146 million
Nursing home care	123 million
Construction	50 million

Private payment including personal and company insurance financed 70% of the total. The consumer paid 96% of the dental bill and 15% of the hospital bill. In recognition of the rising costs of medical and health care, the Connecticut General Assemly in its 1975 session passed a law requiring that all insurance companies in Connecticut offer a complete, comprehensive medical insurance policy as one alternative to its policyholders.

But a far more pioneering effort to address the problem of rising costs had been made back in 1973, during the Governorship of Thomas Meskill. That year, the General Assembly established the Commission on Hospitals and Health Care (CHHC) by passing Public Act 73-117. Primarily the result of long-standing efforts by State Representative Morris Cohen, D.D.S. (Dem., Bloomfield), the Act was based on studies conducted by the Hospital Administration section of the Department of Epidemiology and Public Health at the Yale School of Medicine under the tutelage of Professor John Thompson.[24] Initially addressing the problems of establishing standards for quality of care as well as control of costs of medical services, the Act which finally emerged in 1972 essentially created a rate review commission. The activity involving quality of care was severely objected to by the State Medical Society and was dropped. The resulting Commission was sponsored by Dr. Cohen, Governor Meskill, and the Governor's assistant John Doyle who became its first executive director. It consisted of 15 members: ten appointed by the Governor, one representing the Connecticut Hospital Association, one representing nursing homes, one being a licensed physician representing the Connecticut State Medical Society, one being a licensed registered nurse, and six public members--one public member appointed by the Speaker of the House, one by the President Pro Tempore of the Senate and the three Commissioners of Health, Mental Health, and Insurance.

The original function of the Commission was twofold. The one involved planning functions enabling it to qualify as the CHP "A" agency. These had been formerly located in the Health Department and involved the move of its chief planner, Sally Hirakis, over to head the new Commission's Planning Division. By law, this function involved:

> . . . continuing state-wide health care facility utilization review including a study of existing health care delivery systems; recommend improvements in health care procedures to the health care facilities and institutions; formulate a state-wide health care program for improving delivery of services, including services by individuals though an agreement with a health care institution; recommend to the governor and the general assembly legislation in the area of health care programs; and report annually to the governor and the general assembly, on January first, its findings, recommendations and proposals for improving efficiency, lowering health care costs, coordinating the use of facilities and services and expanding the availability of health care through the state.[25]

Though the legislative mandate was clear, the performance was lacking. As of 1975, Connecticut still did not have a state-wide health care planning program.

In fact, in the 1974 Annual Report of the Commission on Hospitals and Health Care, the director of the planning division, Sally Hirakis, admitted

> The Commission and staff does not feel that there can be a complete final state plan, for the document will be ever-changing and there will be an ongoing process of continual revision to accommodate new technology, changes in the environmental, economic conditions, or social mores. Segments of the total state health plan have already been completed for

> the present time--these include Volume I on Health Manpower which includes data and studies on the distribution of physicians, dentists, and other health professionals; plan on restructuring local health departments; and the segments dealing with the public health nursing agencies and venereal disease control.[26]

Besides assembling data and conducting studies in the areas of its task forces on Open Heart Surgery, Hemodialysis Centers, Primary Care, and Long-term Care, the state "A" agency essentially attempts to coordinate state health activities. It also performs a certificate of need operation, thus serving as a regulatory body of sorts. In the absence of a state plan, however, and all that such a plan implies in the way of assessing state needs and setting priorities for resource development, the agency remains a reactive body. And even as such, the lack of a plan prevents the agency from evaluating proposals for development or change of services in the context of overall state needs or goals. There is little, then, that can be said about the coordinative or regulative activities of a planning agency which, in the end, does not have a plan.

Furthermore, Connecticut's CHP "A" agency was not approved by DHEW to serve as the state's certificate of need authority under Section 1122 of the Social Security Amendments of 1972, P.L. 92-603. Under that law, the "A" agency is to use its plan or standards to evaluate capital expenditures of health care facilities. If those

expenditures are found to be inconsistent with the "A" agency standards, that facility could not be reimbursed under Medicare, Medicaid or maternal and child health programs for any depreciation, interest, or return on equity capital attributable to such expenditures. The staff of the "A" agency in Connecticut attributes the failure to obtain HEW approval to the fact that the legislation which established the CHHC specifically excluded the state operated health facilities and hospitals from the purview of the Commission.[27]

The second function of the Commission involved rate regulation and was performed by its financial division under director Ed Karnasiewicz. It was authorized to review and approve or disapprove, after holding public hearings, any proposed increase in rate schedules for services by any health care facility or institution, any proposals for new functions or services, other than laboratory procedures or social services as exempted by the Commission, and any proposals for capital expendituresby such institutions or facilities in excess of $25,000.[28] The CHHC held over 200 public hearings for this purposes in the first year of its operations.[29] Though many have observed that this process of review has degenerated into a "plea bargaining" arrangement between the Commission and the Connecticut Hospital Association, it still ranks as one of the earliest and most aggressive

attempts in the country to control escalation of hospital costs. The effort was recognized outside Connecticut:

> In Connecticut, the new Commission on Hospitals and Health Care has sweeping regulatory powers over hospital budgets. For the coming year, it plans to hold the state's 35 institutions to an average 8.2% budget increase, one percentage point less than they sought and well under national expectations.
>
> The Connecticut agency has set strict limits on the increases allowed for salaries and equipment and has taken a hard-nosed attitude toward the hospitals' desires to expand costly medical services. . .[30]

Indeed, the CHHC was well-known to the staff of Congressman Roy, the chief sponsor of H.R. 16204 which eventually became P.L. 93-641.[31] The CHHC thus enjoyed a position in the vanguard of rate-regulation and also in combining, at least in organization of the bureaucracy, of such regulation with planning activities. But there were those in Connecticut who said that the emphasis on providers and politicians on the Commission stood as a major obstacle to really effective planning and regulation. The potential for domination of the body by providers, the weakness of its planning operations, and the political forces surrounding appointment to the Commission proved to be serious and possibly fatal flaws of CHHC.

Before the establishment of CHHC, the planning functions of the state's CHP "A" agency were located in the State Health Department (SHD), where it was originated in 1967. From the time of its inception to its transfer to the

CHHC, it accomplished little. Much of this is attributed by its second and current director, Mrs. Sally Hirakis, to a lack of interest and consequently of staff and funds, on the part of the Commissioner of Health at the time, Franklin Foote, M.D.[32] Actually, the state mandate to the health department never clearly included such functions,for the commissioner was charged only to:

> . . . employ the most efficient and practical means for the prevention and suppression of disease, and shall administer the health laws and the public health code. . . be responsible for the planning, development and administration of complete and integrated statewide programs for the control and treatment of tuberculosis persons; the treatment of persons affected with other chronic illnesses, and the medical rehabilitation of chronically ill, physically disabled and handicapped persons.[33]

On the other hand, federal initiatives in the area of planning gradually precipitated changes. For the 1947 Hill-Burton legislation resulted in the addition of "survey functions" to the SHD:

> The state department of health is designated as the state agency to administer the hospital survey and construction act authorized under Title VI, Construction of Hospitals, of the Public Health Services Act as amended, and shall receive and distribute federal, state, and other funds which may become available for such services.[34]

This function implied a certain amount of planning, as noted in the discussion of legislative background to P.L. 93-641. But, reflecting the overall picture across the nation, Connecticut's Hill-Burton agency did little in this regard.

From 1948 to the mid-1960's, the Hill-Burton hospital survey for Connecticut went through a series of modifications but remained essentially based on regionalization of the state around the two centers of Hartford and New Haven. In 1967, however, based on a study conducted for Commissioner Foote by the Medical Care and Hospital Administration group at Yale, and following the establishement of the CHP "A" agency within the SHD, the state was divided into 10 hospital service areas, coincidentally referred to as HSAs. With this development, the function of planning and resources, development, were at least nominally combined in the health department. With the establishment of CHHC, planning became nominally associated with rate regulation. Functional union of these activities was still left to be accomplished in the future.

The basis for drawing the boundary lines for the hospital service areas included such considerations as hospital market areas and hospital commercial service indices.[35] The former refers to the geographic distribution or origin of patients, that is, the hospital's market area, in terms of economic market. The latter, by contrast, refers to the proportion of a given population which uses each of the hospitals available to it. Another factor considered in drawing the lines was the pre-existing regionalization of activities by the state health department. The department had long been struggling with the New England tradition of town autonomy

and was making slow progress. Section 19-75 of the General Statutes of Connecticut established municipal health authorities whose director has jurisdiction over the city, town, or borough.[36] In 1975, there were 141 such local town health departments, 22 with full-time directors and 119 with part-time directors. At the next level, Section 19-106 allows for the voluntary union of towns, cities, and boroughs into district departments of health. In 1975, there were six such areas formed: Aspetuck Valley, Lower Naugatuck Valley, Torrington area, Northwest district, East Shore District, and North Central District. Finally, the SHD operates four regional offices throughout the state: Mansfield Center, Norwich, Wilford, and Shelton. Besides the health department, other departments which regionalized their functions included the welfare department, mental health department, and the department of finance and control.

Of major significance for the boundary lines of the hospital service areas were the Regional Planning Areas (RPAs) of the office of planning and budget of the state department of finance and control. The boundaries and activities of the RPAs is specified by the General Statutes in Sections 4-70a and 4-70b concerned with the planning and budget division:

> The commissioner of finance and control shall establish a planning and budgeting division within the department of finance and control which shall carry out the planning, budgeting, and management activities. . . Responsibilities . . . shall include the following: (a) Budget

> formulation and execution, (b) revenue estimating, (c) review of appropriation and other legislative acts, (d) fiscal analysis, (e) provision of staff and executive secretary services to the state planning council. . . , (f) preparation of statewide or interregional plans in cooperation with other state, interstate, federal, regional or local agencies, (g) preparation of studies necessary for the definition or redefinition of the logical planning regions of the state, (h) promotion and assistance in the formation of regional planning agencies. . . , (i) provision of technical aid and administration of financial assistance for support of regional planning activities. . ., (j) coordination of regional and state planning activities and accomplishment of such planning review activities as may be necessary, (k) accomplishment of studies and evaluations including reports of findings and recommendations. . .[37]

and with regard to the planning areas, the managing director of this division is authorized to:

> (1) Define or redefine the logical planning regions of the state, (2) make available financial assistance for support of regional planning activities. . . , (3) accept any federal funds allotted or available to the state under any federal act for interstate, state, regional, interregional or area planning, budgeting, management or demonstration projects. . . and . . . administer such funds in accordance with state and federal law. The managing director or his designee may enter into contracts with the federal government concerning the use and repayment of such funds and the prosecution of the work under such contracts.[38]

Thus, such areas and the respective agencies established in each to perform these functions as delegated to them by the managing director, serve as the A-95 clearinghouse agencies

for administration of state and federal funds of this nature.[39] In addition, as specified by the General Statutes, each RPA shall:

> . . . make a plan of development for its area of operation, showing its recommendation for the general use of the area including land use, principal highways and freeways, bridges, airports, parks, playgrounds, recreational areas, schools, public institutions, public utilities and such other matters as, in the opinion of the agency, will be beneficial to the area. Any regional plan so developed shall be based on studies of physical, social, economic and governmental conditions and trends and shall be designed to promote with the greatest efficiency and economy the coordinated development of its area of operation and the general welfare and prosperity of its people.[40]

The 11 RPAs in Connecticut were established in the late 1950s. Factors considered in drawing the lines included circulation patterns of newspapers, commuting patterns, local telephone service areas, general hospitals, urban market areas, SMSAs, and opinions of local officials and of the public.[41] They obviously have a significant role in administration of planning funds and their orientation is quite clearly toward commercial and industrial resources. The agency, in many cases, is a council of government (COG) or Council of elected officials (CEO). Nevertheless, the Yale study, and the health department under Dr. Foote saw them as pertinent to hospital planning and their ten hospital service areas were essentially composites of the RPAs. Of course, the RPAs themselves had considered the state's 35 general hospitals as one of the pertinent factors in establishing the areas. But

the decision of Professor Thompson and his students to not violate these lines was to have significant consequences for later developments. For one thing, as of 1967, these ten areas became the ten CHP "B" agency areas. These lines can be seen on maps 1 through 4. The RPAs thus represent a significant state effort to coordinate planning and resources development.

A problem existed, however, in a weakness in their planning abilities. The mandate in this regard was quite global. In the late 1960s, for example, the South Central RPA was in receipt of a proposal to build a hospital in Hamden, Connecticut. Hamden is one town away from New Haven which is the site of the Yale-New Haven medical complex as well as the Hospital of St. Raphael. The study enclosed with the proposal demonstrated the need for such a facility and was sponsored by many of the local physicians in reaction against what they saw as encroachment on private practice by the incorporation of Grace-New Haven Hospital into the academic medical complex of Yale-New Haven Hospital. The actual outrageousness of the proposal was not revealed to RPA officials, however, until completion of a study by the Yale Medical Care and Hospital Administration students. In the ensuing friction, one of the top faculty members of the Yale Medical School and the administrator of the Yale-New Haven Hospital, Dr. Albert Snoke, helped establish Connecticut's first CHP "B" agency. This was the South Central Connecticut

Comprehensive Health Planning, Inc. (SCC/CHP) begun in 1970. Its area of jurisdiction was composed of the south central and the lower Naugatuck valley RPAs plus the town of Oxford. As an attempt to bring together consumers, providers and ellected officials, it took on the burden of planning in the health sector from the RPA.[42]

As of the end of 1974, SCC/CHP was one of five CHP "B" agencies recognized and funded by DHEW, in Connecticut. The other funded agencies included the Hartford, Waterbury, Middletown, and Bridgeport "B" agencies. In addition to the five funded agencies, Connecticut also had six unfunded CHP "B" agencies. These had only recently been organized and they were not able to apply for HEW recognition and funding before the decision was made by HEW to cease funding any new agencies. The HEW decision was made in 1973 and left Connecticut with only a partially developed network of local health planning agencies. The polarization between the five funded agencies which had already begun operations and the six which had not was to have later ramifications upon the HSA designations. SCC/CHP had a 30 member board of directors and a 99 member advisory council.[43] In total, then, Connecticut had 11 "B" agencies with over 1,000 consumers involved in the planning process.[44] The boundary lines are congruous with the state's RPA lines, and the hospital service areas. The 11th CHP "B" area was derived from the ten hospital service areas by the separation of the Meriden-Wallingford area from the south central Connecticut area.

Membership of the SCC/CHP advisory board suggests the nature of their constituency and is included in Appendix C. They enjoy a broad, community-wide support but, true to the Congressional findings about the CHP program in general, they have accomplished little in Connecticut. None has developed a comprehensive health plan.

In fact, the DHEW Assessment Report dated May 10, 1974, suggested that the Health Planning Council, Incorporated (HPC), the CHP "B" agency of the Hartford region had done almost nothing in the four and one half years of its existence. By the end of the fiscal year April 30, 1975, its funding was $212,692 with $128,215 from the federal government and the rest from local sources. As of the date of the report, HPC had no comprehensive health plan, had completed only one study pertinent to the development of a health plan, had almost no involvement in public issues, had no project review activities underway nor any guidelines for performing such review, had not developed an organizational structure which would be "effective in carrying out agency functions," did not give evidence of community participation or education, did not have the information or procedural guidelines for the coordination of health planning in its area, and did not have a data management system.[45] In other words, its staff of six full-time health planners and two secretaries had failed to fulfill even one of the functions which the DHEW considered to be essential

duties of its "B" agencies. Similarly, the Assessment Report of the SCC/CHP agency revealed that in fiscal year ending May 31, 1974, it had received $198,436 of which $136,266 came from the federal government. It had a staff of seven full-time planners and five part-time planners, as well as two full-time secretaries. In its fifth year of existence, it was still in the process of assembling an areawide comprehensive health plan. The report acknowledged that "limited" priority scheduling of areas of need had been done and that an analysis of existing health resources had been started. However, it commented that staff assignments were poor and that the inventory of health resources was based on information obtained from others, often on questionnaires completed by the providers in which they themselves were asked to suggest priorities of need. It was recognized that SCC/CHP had completed studies on the combination of town health departments and that a couple of these studies had led to the establishment of district departments of health. Also, SCC/CHP had taken a public position on several issues related to environment and health and was actively trying to participate in community activities and educate the public. In the absence of a comprehensive health plan, however, the report concluded that the agency could only react to issues and was not able to initiate actions. Furthermore, in the absence of a plan, the report argued that it was not clear how the agency's

involvement in public issues aided its planning efforts, or vice versa.[46] Considering that these two agencies were recognized as the most active in Connecticut, there was little to be said for the achievements of the CHP program in the state.

The General Assembly also recognized that neither the RPAs nor the state health department, nor any other state agency was properly coordinating or adequate to perform planning in such a complex and specialized area. In an attempt to bring some order to this fragmented system and to coordinate state efforts in the field of health, medical and related social services, the Council on Human Services was created in 1973 by Public Act 73-155. Much of its membership consists of the various commissioners involved in health and social services. This was an attempt to address the problem through a generic approach rather than piecemeal or by category, such as epilepsy or cystic fibrosis, or licensing of therapists as had been done in the past. The Council has only recently acquired the funding for staff necessary to carry out its functions, however, as of September, 1974. It is worthy of note that it has already divided the state into five human service areas and has begun to coordinate delivery of services in this manner. It has also received HEW support for a special project dealing with anticipated changes in Medicare and Medicaid. These changes are aimed at affecting both delivery of services and

accounting procedures and would vastly increase the efficiency of these programs for state purposes.

In contrast, the Connecticut Regional Medical Program, unlike the CHPs was quite aggressive since its start in 1969. It could well afford to be for, under the aegis of the Yale School of Medicine as grantee, and the University of Connecticut, its 48 member advisory board oversaw the expenditure of $9.7 million in Connecticut over that period of 1969-1975.[47] Over those years, CRMP did manage to create full-time department chiefs of departments in the local hospitals and at the same time improve the link between those hospitals and the resources of the Yale and University of Connecticut Medical Centers. It also regionalized patient care programs and training programs in heart disease, stroke, and kidney disease. It was also involved in setting up a primary care clinic, a community-wide pediatrics program, in establishing a statewide system of emergency medical services, in hypertension screening, and other services. Also, studies sponsored by CRMP and conducted by Professor Thompson and his students at Yale constituted much of the technical background for the founding of the Bridgeport, Waterbury, and Middletown CHP "B" agencies. CRMP currently compiles and maintains the most authoritative and comprehensive data on developments in Connecticut's health and health planning systems. But in its own community relations, CRMP had had a very stormy history:

> The birth of CRMP was held up temporarily almost a decade ago by an angry Connecticut State Medical Society which accused CRMP of trying to undermine the traditional private practice of medicine in Connecticut.
>
> . . . disputes centered on the classic conflict between the 'planners' and 'doers'--between those who support specific projects and those who plan overall designs.
>
> . . . CRMP, from the start, saw the (planning) vacuum in the state. So it has been trying to do both things at once--supporting patient-oriented programs and pushing its own overall master plan to improve the entire health system.
>
> This double track approach got CRMP into trouble at the start. . . CRMP's first director, Dr. Henry T. Clark, Jr. was accused by the medical society of having a preconceived grand design that he wanted to impose on the state. Clark, said his critics, wanted to centralize health care in the hospitals, instead of the doctors' offices, and wanted to make the local hospitals subservient to the state's two medical schools.[48]

Curiously, CRMP's 48 member advisory board is heavily dominated by providers, having only 14 consumers or about 30% of the total. The providers do indeed heavily consist of representatives of academic medicine. The primary attribute of CRMP, again true to Congressional opinion of the program nationally, was that it was a great source of funds for resources development but its orientation, or at least its perceived goals, lacked a community-perspective and endorsement.

The EHSDS in Connecticut, New Haven Health Care, Inc. (NHHC) had been in place since early 1973 and lacked both funds for resources development or a broad community

representation. Under its executive director, State Senator Lawrence DeNardis, it has to date gathered and analyzed data from New Haven and the six surrounding towns, pertaining to the health resources of the area.[49] As Senator DeNardis summarized the experience of NHHC, ". . . the essential element of the experimental health service delivery system was local management by a voluntarily established, autonomous corporation with representation from all the major interest groups concerned with health care."[50] Having to compete with the money of CRMP and the community-wide consumer base of the "B" agencies, the original input of NHHC into the system was nil. Its composition is indicated in a table in Appendix C.

Finally, as part of federal initiatives in quality control, Connecticut is one of the few states in the country to already have its Professional Standards Review Organizations in place. These agencies, composed of boards of providers, are required by the Social Security Act. They are required to establish standards of quality of care for the purpose of determining what will be paid for by the Medicare and Medicaid programs. There are four PSROs in Connecticut. As the State Medical Society is based on County Medical Societies, the PSRO areas follow the old county lines. Activity under this program is still in the

developmental stages as the support center for the program, Connecticut Medical Institute is just gearing up for the task of data collection and analysis.[51]

As all these examples of initiatives at both the federal and state level indicate, the funds for services and resources development came first. These were then followed by attempts at planning and regulation to control the spending of those funds.

Analysis

In most ways, the Connecticut experience in health planning up to 1975 was parallel to that at the national level. The exceptions were in its attempts to regulate rates and in the conjunction of its CHP areas with planning and funding areas established to promote commercial activities.

Some points pertinent to later events include:

1. CRMP fit the Congressional impression of the RMP program in being a well-funded, largely successful resources development program which lacked orientation to the community, in either its organization or its priorities.
2. CRMP differed from the national program in its very early attempts to combine its resources development and regional coordination efforts with some sort of plan for the state's overall system of health care.

3. CRMP definitely had a bad public image and necessarily suffered in competition with the local "B's" in this area.
4. The CHP program in the state also fit the Congressional image in enjoying a wide community-based constituency with consumer-orientation but with a notable dearth of substantial achievements.
5. The CHP "B" agencies were congruous in area with the state's RPAs. Thus they were allied in their planning efforts with the state department of finance and control and the various councils of government and councils of elected officials which constituted many of the planning agencies.
6. The provider dominated organizations, PSRO and CRMP were either organized along archaic regional boundary lines and did not address planning policy or possessed poor public relations such that their impact on planning was severely compromised. The consumer and governmental organizations, CHP and RPAs enjoyed a broad-based constituency but lacked sufficient resources or direction of policy to have a great impact.
7. Planning at the state level had variously been associated, at least pro forma, with resource development (Hill-Burton program in state health department) and with rate regulation and facilities

construction regulation (CHHC). In neither case was a plan produced or functional coordination achieved.

8. The state department of health was essentially out of the picture in planning or regulation with the assignment of such duties to CHHC. It was left only with actually disbursing the Hill-Burton funds.
9. CHHC was a pioneering and innovative effort to control rate increases and restrict indiscriminate expansion of facilities and services. At least in form, these were supposed to be coordinated with planning efforts. This latter aspect of the commission also was unique.
10. The composition of CHHC made it a highly political body and it had yet to withstand the test of a change of administration (from Republican Meskill to Democrat Grasso).
11. The existence of CHHC divided the state's efforts in the realm of health between two agencies, CHHC and the health department.

It was upon this system that the changes mandated by P.L. 93-641 would have to be imposed, starting in 1975.

CHANGES DURING 1975

The structure and process mandated by P.L. 93-641 focuses a great deal of responsibility and initiative on the office of the governor of each state. The newly elected Governor of Connecticut, Ella Grasso, assumed office on January 8, 1975. As would be expected, with the appearance of P.L. 93-641 on January 4, a major concern of the existing agencies and organizations concerned with health planning was how best to influence the Governor. On January 21, 1975, the Secretary of the Department of Health, Education and Welfare, Caspar Weinberger, officially notified the various state governors of their responsibility in designating Health Service Areas under the new law. By February 8, 1975, Governor Grasso had assigned Dr. Fred Adams to the task of laying out the HSAs. Connecticut met the DHEW deadline of May 3, 1975 for submitting Health Service Area requests and Governor Grasso announced her plan to divide Connecticut into five areas at a press conference on May 6. It was a fast pace, by bureaucratic standards, and a lot happened along the way. It is difficult to discern just precisely what did happen, but the events make an interesting story.

In addition to the usual confusion of an incoming administration in its statehouse, Connecticut also witnessed quite a scramble in the public health sector. The extent was unusual, even by Connecticut's already highly politicized

system. Being the expert politician that she is, Ella Grasso must have anticipated the problems she might encounter upon trying to assume leadership in Hartford. For she had already assembled a Volunteer Transition Staff under the leadership of one Dennis Rezendes, a figure quite well known in Connecticut politics. A deputy under former New Haven Mayor Richard Lee, Rezendes coordinated a large group of volunteers throughout the state with background and expertise in a wide range of fields, one of which was health. The genesis of this Volunteer Transition Staff is shrouded, but between himself and Acting Finance Commissioner George Conkling, Rezendes assembled the experts and organized them into groups for the purpose of looking at specific issues, identifying problems and constraints to their solution, anticipating "time bombs," and prioritizing the State's needs. Among the groups was the Human Services Group, chaired by Morton Coleman, Dean of the University of Connecticut School of Social Work. Finally, this Group was divided into seven task forces, such as Welfare, Aging, Children and Youth Services, and so forth. One of these was the health task force headed by co-chairman Fred Hyde of the Connecticut Hospital Association and Cornell Scott, Director of the Hill Health Center of New Haven. The members of this task force are listed in Appendix D. By way of background, it should be pointed out that Susan Addiss is a member of the Advisory Board of the South Central Connecticut CHP "B" agency,

Dr. Gaintner is on the Advisory Board of the Connecticut Regional Medical Program, Lou Kaplan is Assistant Dean for Community and Government Relations at the Yale School of Medicine (part of a program originally funded by CRMP) and staff Gary Sax is also from the Yale Medical School, Office of Regional Affairs. Besides Human Services, other groups included Economic Development, Education, Community Development, Transportation, and Natural Resources. Each group was to begin work around January 2, 1975, and complete its "briefing book" for the Governor by February 10. After that, the transition staff would be thanked by the Governor and would disband. No report for public distribution was planned.

A memo to this effect is included in Appendix D. Coordination with the Governor apparently took place through her executive assistant, Nancy Lewinsohn.

But all had not been idle at the offices of CRMP during the inauguration. They had formed a transition staff of their own whose function was remarkably similar to that of the Governor's transition staff. Proposed back in September, the membership was to be as shown in the Table in Appendix D.[52] Notable persons included Morton Coleman and Fred Hyde. By October 22, all except Dr. Van Syckle had agreed to serve.[53] Dr. John Patterson, as the chairman of CRMP's Ad Hoc State and Regional Health Resource Committee, had approached CRMP's officers as early as October, 1974, with the view that they might see their role as helping the new governor in delineating

state policy and health issues while building understanding of CRMP's track radio in its basic function, health resource development.[54] Dr. Patterson was to meet with Governor Grasso on December 27. This happened to be the very day that Rezendes first met with his Group chairmen.

At its December 17 meeting, the CRMP executive board, in addition to being informed of the activities of its Patterson Committee, heard from its executive director that H.R. 16204, the pre-conference form of what would become P.L. 93-641, was being sent to conference the next day and that it had a possibility of passing.

The results of Dr. Patterson's meeting with the governor-elect on December 27, are unknown, but the outcome was presumably positive as a follow-up meeting took place on January 17, 1975. Involved were Dr. Patterson, Russel D'Oench, chairman of the CRMP advisory board, Ed Morrissey, CRMP's executive director, and the governor. CRMP proposed to aid in transition efforts, emphasizing the rapid time frame of the the new law and CRMP's desire to be a resource to state government. The Governor apparently wanted CRMP's aid at this point and conveyed to them her sense of burden with the implementation of P.L. 93-641. Subsequently, a letter was received by CRMP from George Conkling, Acting Commissioner of the Department of Finance and Control and Dennis Rezendes' partner in the Governor's Transition Staff activities. The letter, apparently sent on behalf of Governor Grasso,

requested CRMP's assistance and financial support to the tune of $25,000 to support an analysis of state policies and services presently under way.[55] The request was approved by the CRMP Advisory Board at its meeting on January 23.

To the observer, this must seem to be a rather shady affair. It was obvious that CRMP, like its sister Regional Medical Programs throughout the country, was destined to be replaced under the new law. The formation of the Patterson Ad Hoc Committee is surely an indication of CRMP anxiety over this and represents an effort to find a means to preserve itself. Likewise, the offer to assist the new Governor and familiarize her with the complex health scene in Connecticut is certainly justified by CRMP's extensive involvement and experience in it. On the other hand, the Governor already had her own Transition Staff as should have been known to Morton Coleman and Fred Hyde who were on both the CRMP Ad Hoc Committee and the Governor's Human Services Group. It is unclear, however, that the CRMP Committee ever actually met as a group, thus making it even more questionable as to its purpose with regard to aiding the Governor. Finally, that a non-State government agency should fund the efforts of a volunteer staff to the Governor surely must be questioned.

And indeed it was. By late January, the CRMP support had somehow grown to a figure of $75,000. Both the Hartford Times[56] and the Hartford Courant ran stories describing the

scramble, noting the apparent competition to influence the Governor, and suggesting that CRMP's funding offer just might be interpreted by some as a bribe.[57]

It is out of this frenzied state of affairs that the idea of having the Governor appoint an "independent czar" charged with setting up the State's machinery for implementing P.L. 93-641, first came into being. Called the "Moses solution," it apparently originated from within the Health Committee of the Governor's own Transition Staff. As the name implies, the essence of it was that the person selected should have the complete confidence of the Governor with respect to neutrality among the various interests involved and who, once the system was set up, would not himself take up a position in the new "promised land." Suggested for the role of Moses at the time were such persons as Yale President Kingman Brewster or former University of Connecticut President, Homer Babbidge. The Governor bought the solution, but without the Moses.

On February 7, 1975, Governor Grasso charged Dr. Frederick G. Adams with the task of helping her put P.L. 93-641 into effect. If behind the scenes activity in Connecticut had been frenzied up to this point, they very quickly became frenzied out front. A Hartford dentist and Vice-President of the University of Connecticut, Dr. Adams' first task was to divide the State into Health Service Areas. The deadline was set at May 3 by DHEW, less than three months away.

Lest too much emphasis be placed on this sequence of events as being the primary influence on the Governor's designation of someone to implement the law, it must be noted that the "notice of initiation of proceedings" from the Secretary of the Department of Health, Education and Welfare to the Governor, as required by the legislation (Sec. 1511), assumed that a staff person or state official would be assigned to the task. At the same time, the explanation of the requirements of the law as to the nature of the Health Service Areas and the process of their selection, as contained in that letter, is quite suggestive of the magnitude and complexity of the task.[58] The notice was dated January 21, and appeared in the Federal Register of January 28. Before the end of the first week of February, the Governor had already received proposals from various health groups calling for the division of Connecticut into from two to five areas. It must have been in response to both the administrative and technical complexity of the law, as well as the political struggling that the Governor settled on the "Adams solution."

The astute politician will immediately realize that an appointment of this sort is never a solution in itself. In the case of Connecticut and P.L. 93-641, it at least imposed a formal channel for feeding information to the Governor. And, perhaps more importantly, the whole process seemed now to be open to the public. Indeed, the Minutes of the first CRMP Executive Board meeting following Dr. Adams'

appointment contains the assessment by Executive Director Ed Morrissey that CRMP's role is now seen as limited to a technical and information-providing service with input going to Dr. Adams.[59] Also noted was the resignation of Dr. Patterson as Vice-President of Health Affairs at the University of Connecticut Health Center. But Connecticut can never be accused of having a shortage of active and alert professionals and agencies in the field of health planning. For back on January 16 and 17, there was held at the Department of Health, Education, and Welfare, in the Office of Comprehensive Health Planning in Baltimore, a session on Health Resources Planning. Present were representatives of the five funded Connecticut CHP "B" agencies, the Connecticut CHP "A" agency, the Connecticut Commission on Hospitals and Health Care, the Connecticut State Health Department, Connecticut Regional Medical Program, New Haven Health Care, Inc., and the Yale Office of Regional Affairs.[60] On February 6 and 7, the National Governors' Conference in Chicago, with representatives of DHEW present, similarly discussed the new planning law. Again, Connecticut was well represented by persons from the state health department, the department of finance and control, the state welfare department, and the Governor's Transition Staff.[61] Membership in the latter had apparently grown to include Rosemary Johnson, executive assistant to the commissioner of the health department

and Roslyn Fishman, executive director of the South Central Connecticut CHP "B" agency (SCC/CHP).

One of the results of the Governors' Conference was a statement questioning the public accountability under the new law. The governors complained that, "the legislation as enacted, while containing some amendments sought by governors, is still completely unacceptable in its lack of clear lines of public accountability for developing plans and making decisions that affect the delivery of health care services." They went on to request that Congress evaluate the new health law's adequacy and an evaluation of HEW's policies in implementing the new law. They pointed out that many states had created sub-state districts, with federal encouragement, to reduce overlap and duplication and to support comprehensive planning across functional lines. As a minimum, they urged that the following policies guide its implementation:

> --the governor, consulting with local officials, should have the authority to designate health service areas without regard to such arbitrary criteria as population minimums of 500,000 and prohibition of division of SMSAs
>
> --the governor, consulting with local elected officials, should be responsible for designating the health systems agencies (HSA) at the local level to serve as the publicly accountable organization for health planning and decision making
>
> --the governor should be responsible for establishing and structuring health planning and resource development at the state level to ensure consistency with state law and policies and to facilitate public accountability rather than autonomous decision making

> --the Secretary of HEW should have authority to intercede in state health planning activities only under highly unusual circumstances.[62]

By now, everyone seemed to be getting interested in studying, analyzing, and interpreting P.L. 93-641. As of February 7, Dr. Adams was interposed between these professionals and agencies and the Governor. There was much activity and he obviously had much homework to do.

Dr. Frederick G. Adams, having received the degree of Master in Public Health from Yale University in 1970 certainly was no stranger to the Connecticut health scene. In addition to being a practicing dentist in Hartford, his past experiences included the commissionership and past chairmanship of the Connecticut Commission on Human Rights and Opportunities, which apparently occasioned his initial encounters with the then State Representative Ella Grasso. He also was involved in the development of the School of Allied Health Professions at the University of Connecticut, having written several papers on the subject, including a planning program grant application to CRMP. He served as Dean of the School of Allied Health Professions at the University of Connecticut from 1972 to 1974 at which time he became the University's Vice-President for Student Affairs and Services. Dr. Adams had also served as a Connecticut delegate to the Governing Council of the New England Public Health Association and was past President of the Connecticut Institute for Health Manpower Resources and was still a consultant to the Veterans

Administration Health Manpower Training Assistance Review Committee. His past experience served him well, for the task he faced was quite monumental. To accomplish it, he employed a process strategy which, he said, had worked for him before. This was essentially a systematic data collection and public hearing methodology.

The elements which Dr. Adams had to plug into this theoretical framework were several. The first and foremost were the constraints of the law itself and the federal guidelines, which had been issued by this time, by the DHEW. Second was a time frame within which to accomplish the large number of tasks required. And finally, assembly of a staff which could competently perform those tasks. The mechanism he finally used was certainly unique.

But, on the other hand, so was his goal. The primary pertinent thrust of the DHEW Guidelines, was that the HSAs be as congruent as possible with existing boundaries for SMSAs, PSROs, regional planning areas, or State planning administrative areas. In terms of the process of determining the areas, the Guidelines note the mandatory consultations required of the Governor in determining HSA boundaries. These include State ("A") and areawide ("B") CHP agencies and RMPs. Further, consultation with EHSDSs, NHHC in this case, PSROs, various State health and related agencies such as the Health Department, Mental Health Department, Hill-Burton agency vocational rehabilitation agency and so forth, major health provider groups such as the State medical society,

hospital association, etc., voluntary health organizations, and appropriate consumer and public interest groups was urged. Some public format for such consultations was urged, but written statements, meetings with agency heads, and formal resolutions by legislative bodies was allowed. Finally, waiver requests to split SMSA lines would be entertained and would largely be weighed against the comments of local governments, providers, and the general population that the proposed area requiring the split was indeed appropriate for effective health service planning and development. In the area designation plan itself, as finally signed by the Governor and sent to HEW, copies of actual comments resulting from the consultations were required only from federally funded CHP agencies and RMPs and from groups and agencies involved in waiver requests. Principle responsibility for reviewing the health service area designations would rest with the HEW Regional Office. Formal approval authority, however, would reside in the Administrator of the Health Resources Administration.[63] By this time, DHEW had undergone another of its reorganizations and had established a separate Bureau of Health Planning and Resources Development and had placed former Director of the Office of Comprehensive Health Planning, Eugene Rubel, at its head. From this point on, most of the State's interaction with DHEW was through its Region I office. In this way the federal mandate was laid out and the various levels of responsibility for

implementation began to stratify. At the level of the Governor's designee, the task seemed essentially that of compiling and rationalizing the basic data.

The political milieu surrounding Dr. Adams entrance into the scene suggests that there is more to it than that, however. Clearly, the intent of the law, even without a reading of the Guidelines, is for a pluralistic input into area designation. And in Connecticut it was already clear that the various interests were ready to speak. So much so that perhaps one of the political functions of Dr. Adams selection might have been to provide an open, public forum and a formal pathway for information and opinion to flow, that is, to give that appearance. For no one could doubt that final authority rested with Governor Grasso. Ultimately, the goal was to influence her. This was surely in the mind of Fred Hyde, and no doubt echoed others adept at Connecticut's health system, when he said:

> Reportedly, the structured system which Dr. Adams is using has received positive reaction from regional officials of the Department of Health, Education, and Welfare. At the same time, the system, and especially the composition and work of the task forces, have caused considerable anxiety in Connecticut among those who would like to know 'what is going on.'[64]

The subtlety of Dr. Adams role was not lost. The system he created was highly structured. Whether the actual path of influence was equal to this system is doubtful. From this time on, the question would be, "Who is actually calling the

shots?" The Commissioner of Health? Dr. Adams? Nancy Lewinsohn, the Governor's executive aide? Possibly, the commissioner of finance and control, newly appointed Jay Tepper? Such is the nature of the system.

Perhaps pertinent was the abolishment at this time of the Council on Human Services as an independent body. Governor Grasso administratively relocated this agency in the office of her Secretary of the State, Gloria Schaffer. Mrs. Schaffer had worked extensively in the past in the state's health legislation while a member of the Committee on Public Health and Safety of the General Assembly. In fact, she had been active in the study of hospital service areas conducted by Professor Thompson at Yale.

It was also apparent quite early in the year that the Governor was definitely not impressed by Dr. Douglas Lloyd, her commissioner of health. Having been appointed in November, 1973, by Governor Thomas Meskill, it was widely considered that James Whitten, chairman of CHHC had been instrumental in bringing Dr. Lloyd up from North Carolina. Governor Grasso was known not to be particularly partial to the predominantly Republican Commission on Hospitals and Health Care, either. Dr. Lloyd also encountered problems in reconfirmation by the General Assembly early in 1975 when questions arose as to his travel expenses and his staff. Anonymous charges were given to the Senate Executive Nominations Committee of the State General Assembly

which claimed

> . . . that Dr. Lloyd has taken an excessive number of out-of-state trips during his term in office, many of which were not related to his duties as commissioner.
>
> They also claim that he has appointed a handful of persons to key positions in the Health Department in violation of the state merit system. Some of these positions are filled by what the statement calls special assistants.[65]

Though the commissioner was eventually reconfirmed, it was perhaps as a result of this adverse publicity that he and his executive aide maintained a rather low profile throughout the first half of the year.

By the middle of February, groups around the state were already considering their position on how many HSAs the state needed and where they should be, as Dr. Adams was drawing up his time frame and the system he would use to gather those opinions. Necessarily condensed by the tight time constraints specified by P.L. 93-641, Dr. Adams had already assembled a full-time staff of five, organized three working committees, scheduled ten public hearings throughout the state, and begun making consultations before the month of February was out. One of Dr. Adams first actions was to pay a visit to Dr. Gertrude Hunter, of the HEW Regional Office.[66] From this point on, the working relationship between Dr. Adams and Dr. Hunter was very close. As noted earlier, HEW was very favorably disposed to Dr. Adams'

method and this close liaison gave final sanction to him and his committee as the primary and sole channel of data input.

The fact that Dr. Adams originally planned for four committees, of which Committee I was to be the Statewide Health Coordinating Committee called for under Section 1524 of P.L. 93-641, suggests that he had a rather broad interpretation of his function and intended to make recommendations to the Governor regarding the State Agency and SHCC as well as the HSA boundary line designation.[67] To help him he convened Committee IV, which became Group I in the final report, called the Director's Colleague Committee. A group of 24 persons well known to Dr. Adams, their main function seemed to be as liaisons between Dr. Adams and the task forces of Committee III, or Group II of the final report. It was they who had to see to it that the information input was comprehensive and complete and on schedule.[68] Their backgrounds were varied and a few, such as Fred Hyde, Rosemary Johnson, Lou Kaplan, Cornell Scott, and Courtland Wilson were already quite extensively involved in the implementation process by way of the CHA, the State Health Department, the Yale Office of Regional Affairs, South Central Connecticut CHP, and NHCC, respectively. The full membership of this committee is included in Appendix E. Their functions seems to have been more administrative than representative. As liaisons, they were assigned in pairs to oversee the function of each of the

17 task forces which comprised Committee III (Group II) of the Resources Development Committee. Each task force had from four to 23 members and the total was 161 persons. The fields covered are indicated in the table included as Appendix E, Part II. An attempt to get some comprehensive representation is apparent at this level. The Comprehensive Health Planning task force was chaired by Anna Schulerud of the Housatonic Valley CHP. Members included Roslyn Fishman, Marcus McCraven and Irene Smith of the South Central CHP, Ralph Pollack and Fred Margolis of the Hartford CHP, the Health Planning Council, Inc., and Sally Hirakis of the State's CHP "A" agency, CHHC, as well as persons from the Bridgeport, Waterbury, Middletown, and Meriden-Wallingford CHPs. The legislative task force was chaired by Dr. Morris Cohen and included Senator Anthony Ciarlone who, with Dr. Cohen, co-chaired the General Assembly's Committee on Public Health and Safety. Also a member was Senator Lawrence DeNardis, the Executive Director of NHHC. Senator DeNardis was also chairman of Dr. Adams' NHHC task force. The CRMP task force was chaired by the ubiquitous Ed Morrissey. The State Agencies task force was chaired by Dr. Douglas Lloyd, Commissioner of the State Health Department and included the Commissioners of the State Welfare Department, Mental Health Department, Department of Children and Youth Services, the Commissioner of the Commission on Hospitals and Health Care, Rosalie Lang of the Council on Human Services and

Horace Brown, the Managing Director of the Planning and Budgeting Division of the State Department of Finance and Control. The "sounding board" for information coming in through these channels was Committee II, or Group III in the final report, known as the Demography Committee.[69] Armed with this extensive and highly structured organization, Dr. Adams began his assault on the State's health planning system.

A total of ten public hearings was scheduled for between March 3 and April 2. The first four, beginning on March 3, were to be in Hartford. The first outside the Hartford area would be in New Haven on March 19. Subsequent hearings were set for Stamford, Bloomfield, New Milford, Mansfield, and New London. Prior to each hearing, local elected public officials were familiarized with P.L. 93-641. In all, 340 people attended the hearings with 129 testifying for the record. All told, 116 elected officials or their designees were consulted. In addition, Dr. Adams and his staff were invited to the monthly Greater Norwalk Community Council meeting and a special meeting on P.L. 93-641 at the Bridgeport City Hall in early April.[70] A good deal of testimony was thus gathered but served mainly to highlight the information Dr. Adams would get through his task forces and personal visits with key groups and persons.

As a result of these contacts, Dr. Adams probably had a pretty complete picture of the various points of view even

before the first public hearing. His visit log contained in the final designation plan makes this fairly clear. Therefore, though he pledged not to begin writing until March 24, the conflicting forces at work throughout Connecticut must have been obvious to him long before.

His first visit apparently was made on February 18, to the Housatonic Valley Health Planning Agency, the CHP "B" agency whose executive director, Anna Schulerud, was the chair of his CHP task force. By this time, the 11 CHP "B" agencies of Connecticut had already met on February 14, to discuss the matter of HSA divisions for the State. Apparently, the consensus of these agencies was that the Regional Planning Areas of the State's Department of Finance and Control, were logical building blocks for the new HSAs. They also agreed that the Lower Naugatuck Valley towns of Oxford, Seymour, Ansonia, Derby and Shelton should be kept together with the South Central Connecticut CHP area, as should Milford. As a result of this conference, the five funded "B" agencies signed a position paper advocating that the State be divided into as many areas as possible as allowed by the law.[71]

A visit to the Council on Human Services on February 20, suggested that the CHS was not committed to any set of lines at that time. Dr. Adams also visited with Horace Brown and others at the State Planning and Budgeting Division of the Department of Finance and Control, on the 20th. Contact was made with the legislative task force's State

Representative Morris Cohen and Senator Larry DeNardis on February 27. Also on that day, Dr. Adams spoke with Professor John Thompson at the Yale School of Public Health. Even at this early date, some of the major problems of health service area designation were anticipated by Professor Thompson. Among these was the observation that Middlesex County was likely to be severely disrupted because it is composed of parts of three separate SMSAs. Professor Thompson also indicated that the towns of Meriden and Wallingford traditionally have worked as a package and that planning efforts should place high priority on preserving the unity of the five towns of the Lower Naugatuck Valley.

A visit to the Connecticut Regional Program offices in New Haven on February 28, seems to have been somewhat strained. Some of the early discussion appeared to be an effort by CRMP officials to see through the "strategy" of Dr. Adams' implementation plans. In response to the questioning, Dr. Adams admitted that one of his aims was to involve many agencies and people and that his plan goes beyond what the law actually required. He also mentioned that the legislative task force role was obvious inextricably related to the budget. Also at this meeting, Mr. Ed Morrissey offered the loan of CRMP staff to the Governor's office to assist in task development, a sum of $75,000 from CRMP to assist with the task of implementation, and CRMP members to function as advisors. All were declined by Dr. Adams.

Ed Morrissey did accept the chairmanship of the CRMP task force, however, and was asked to submit a task force report to Dr. Adams by March 24.

By the time of the first public hearing, March 3, in Hartford, Dr. Adams had also talked with the State Attorney General, the Commissioner of the Welfare Department, and the Commissioner and staff of CHHC.

Evidence of high public interest and initiative prior to the beginning of public hearings also was noted in the Hartford Courant, February 13. Dr. Henry Clark, former head of CRMP suggested that Dr. Adams draw on the staff of the Yale and University of Connecticut medical schools as a resource. Already, attention had been given to the five service districts of the Council on Human Services, as a possible basis for the HSA designation. And New Haven Health Care, Inc. had offered its services to Governor Grasso to help in dealing with P.L. 93-641.[72]

From without the medical community, Milford Mayor Joel Baldwin had already sent a letter to Governor Grasso dated February 20 asking that Milford be associated with New Haven rather than Bridgeport. The latter event was even noted in the New Haven Register.[73] The rationale was that a large segment of the Orange, Connecticut, population utilizes the Milford health facilities. And Orange is a part of the New Haven SMSA. Also noted were the longstanding relationships such as Milford's role as part of the Greater New Haven Hospital Planning Association, the

Visiting Nurse Association, the New Haven Cancer Society, the New Haven United Way, and the South Central Regional Planning Agency.

By February 24, 1975, Dr. Adams was also in receipt of a letter from the Lower Naugatuck Valley (LNV) Community Council, Inc., an affiliate of the South Central Connecticut Comprehensive Health Planning, Inc. (SCC/CHP). In that message, the many longstanding cooperative efforts between the five towns of the LNV were cited. These included mutual dependence on a central hospital, Griffin Hospital, the LNV District Public Health Department, the Valley Transit District, Public Health Nursing and Homemaker Services, Inc., Valley Medical Society, and Valley United Way. Also noted was the existence of a Council of government made up of the four chief elected officials of Ansonia, Derby, Seymour and Shelton and their role as an RPA. It was also pointed out that much work had been invested in building up a relationship between these organizations of the LNV and the planning and health services delivery system of the South Central area. This included the LNV participation in planning with SCC/CHP, the area "B" agency, the South Central region for drug planning and emergency medical services, inclusion with New Haven as part of the New Haven Welfare district and the South Central Regional Office of the Connecticut state health department. Therefore, although a waiver to violate SMSA lines would be required, Dr. Adams was strongly urged to

consider keeping the valley as a unit and including it as part of the South Central area HSA. A groundswell had begun and by the time of the public hearing scheduled for New Haven, on March 19, the cry of "Save the Valley" was being shouted by Dr. Adams' staff. Subsequent letters would be received by both Dr. Adams and Governor Grasso from the Regional Planning Agency, the Valley council of elected officials and the various state senators and representatives all advocating keeping the Valley together and include it as part of the South Central Connecticut area.[74]

Indeed, the substance of the testimony at the New Haven hearing was that the five LNV towns should be kept together and that the group should be kept as part of the South Central area with New Haven. Most of the speakers were representatives of the groups and agencies already noted in the earlier letters to Dr. Adams. The same held for testimony requesting that Milford be kept with the New Haven area.

By mid-March, sources of input ranged across the whole spectrum of interests in Connecticut's health planning system. A more than ample case had been made for keeping Milford and the LNV with the South Central area. Indeed, major controversy now seemed to shift to the question of just how many HSAs there should be. Considering that Connecticut's population was around 3.1 million, the number of HSAs could range from five to two, or even one if a population waiver was requested to that effect. In light of the complexity of

Connecticut's health planning system, the strategies for survival and influence in the new system would rest largely on the question of how many areas there would be. For example, fewer areas for the state would favor those agencies which operated on a statewide level or which were promoting control of planning by fewer people in more centralized agencies. A larger number of areas, however, would favor decentralization and a local orientation for planning, a goal clearly consistent with Congressional intent. Given the history of planning in Connecticut, however, increasing the number of areas sought for the new system would increase the number of alternatives available from already existing divisions of the state.

The breakdown of agency positions on the number of areas suggested that just such strategems were being employed. This polarization was publicly evident at the New Haven hearing. Gunar Bohan, M.D., director of health for the city of Meriden and a member of the Meriden-Wallingford CHP "B" agency went on record as requesting that Connecticut be designated as a single HSA with the agency being CHHC. By having the 11 CHP "B" agencies become subarea councils, she argued, "a layer of bureaucracy would be eliminated."[75] It might be added that adoption of such a plan would give a measure of protection for the future of her unfunded "B" agency. Also, a single HSA might serve to unify the disparate functions of the existing "B's" while allowing them to maintain their local representation. A similar approach was advocated by

Anna-Marie Foltz, a member of the New Haven board of adlermen and also a member of the Health Policy Group at Yale. She suggested that the planning areas should be kept large to avoid fragmentation and should be around two in number, but certainly no more than four. In this statement, she also commented that in the past, the state had had hospital planning, not health service planning.[76] She also added that the health department should be designated the State Agency and should include the functions currently assigned to CHHC. Though she made it clear that she was speaking only for herself, the pertinence of this particular comment to the final outcome of the implementation of P.L. 93-641 in Connecticut certainly raises the question of the influence she or her colleagues had on the process.

Similar support for two HSAs was offered at the next public hearing in Stamford on May 21. This came from Dr. Edgar Geibel, executive vice-president of Stamford Hospital. He noted that the state could be naturally divided between its two major health centers--the University of Connecticut Medical Center and the New Haven area hospitals. To create further divisions, he argued, would fragment the state.[77]

There never was any real public support for three HSAs.[78]

In fact, however, the only way in which all federal criteria would be met for Connecticut was by dividing it into two or three HSAs.

The position that there should be four HSAs was assumed by two groups for very different reasons. At the New Haven hearing, Fran Roberts of the State Mental Health Department suggested that the five Council on Human Services areas be used with a combination of the two western areas to meet the population requirements.[79] In fact, however, this still leaves the eastern area with insufficient population. At the Stamford hearing, Dr. Stewart A. King, president of the Fairfield County Professional Standards Review Organization, advocated four HSAs based on the four PSRO areas of the state.[80] This was to become the official position of the state's PSROs. These lines have nothing much to do with any resources or services delivery other than that the state's physicians are organized into county medical societies. The CHP agencies also proposed four HSAs but only as a second choice if the governor wished to avoid requesting the waivers necessary for five.

The position that there should be five HSAs was consistently advocated as the best solution by the state's five funded CHP "B" agencies. At the Stamford hearing, Eugene Michaels, Director of the Health Planning Council of Eastern Fairfield County located in Bridgeport, suggested five areas, arguing that, ". . . by having more districts there would be more real participation by citizens. . . Participatory planning demands that decision making power be brought as close to the people as possible. . . if there were only one or two

agencies in the state the subdistricts in the agencies would only be advisory."[81] Roslyn Fishman, executive director of SCC/CHP at the New Haven hearing also had argued that five areas should be established to maximize participation of consumers and input of local government and provider interests. She further argued, however, that the RPAs be used as the basis for determining the boundary lines as these were, ". . . based on sound planning criteria and represent established and viable political cooperations which are basic to effective planning, including health planning. . . on the other hand, in Connecticut SMSAs are not basic units for health and mental health planning or physical planning." Finally, she pointed out that the five operating "B" agencies already meet some of the basic requirements of the law and could thus serve as core groups for formation of the five health systems agencies.[82]

This advocacy of five HSAs was the official position of the five funded "B" agencies. As noted earlier, they along with the six unfunded "B's" had been meeting since January over this issue. At the February 3 meeting, the group already had a consensus that a larger number of HSAs was to be preferred. Also at this meeting, Mrs. Hirakis of the "A" agency pointed out that any group within an HSA area can apply for funding and that HEW decides on which agency will get it. But, she added, the Secretary must ask the governor for comments and, in turn, great weight will be given to endorsements

by CHP agencies and the RPAs. She further observed that the state agency would have the greatest potential in CHHC.[83]

Two meetings later, on February 24, 1975, Mrs. Hirakis informed the group that the Region I HEW Office was advising that SMSA waivers would be possible if strong documentation was provided and that population waivers would not be possible for Connecticut. Also, a consensus had been reached during a workshop held by the office of state planning that RPAs be used as the smallest areas and that agencies requiring larger populations be composed of several RPAs.[84] It also became evident at this meeting that each "B" agency was concerned primarily with the area boundaries for their particular area and no consensus was reached. The Meriden-Wallingford "B" agency contrasted with the rest in advocating a single HSA with the 11 "B's" as subarea councils. The unfunded "B" from the Litchfield Hills-Northwest area consistently advocated a plan which would keep them as an area separate from the funded "B" of the central Naugatuck Valley in Waterbury.

By March 4, the only consensus among the "B's" was that priority be given to using RPA boundaries in constructing the HSAs and that the maximum number of areas as possible be designated, as would be consistent with the legislation.[85] The basis of disagreement continued to be the issues as before.

In their report to the Adams task force on CHPs, this ad hoc committee finally advocated five HSAs whose boundaries

maintained the integrity of RPA lines and consisted of aggregates of existing CHP agencies while "relatively few SMSA waivers" were required.[86] The report stated that this was the position of the majority of "B" agencies. A map showing their recommendation is included as map 16.

Consequent to CHP's stand, a large volume of letters and resolutions were received by the Adams staff from consumers, providers, councils of government and of elected officials throughout the state. Especially numerous were those from the central Connecticut RPA and from the Northwest CHP area. All were in favor of maximum consumer and local control and therefore of maximizing the number of HSAs. Most deferred to the five HSAs adopted by the "B's" but many went beyond this to suggest six or more HSAs.[87]

By way of contrast, the CRMP task force recommended two HSAs. The NHHC task force advocated three HSAs while that of the PSROs suggested four. The Connecticut Hospital Association advocated either one ro two HSAs. They also suggested that the CHHC be designated as the State Agency and that this body should also be merged with the SHCC. And, in the event that there was one HSA designated for the state, they recommended that it too be merged with this agency.[88]

Among the state agencies, the Council on Human Services favored one HSA with five regional subarea councils based on its own five CHS areas. The two departments of children and youth services and aging both favored the CHS proposal since

they had already begun to regionalize their functions on this basis. The department of finance and control favored a single HSA with five subarea councils and the health department favored five HSAs. The legislative task force and the CHHC task force commented only that CHHC should be the State Agency.[89] The state agencies made public their findings at a meeting of the Connecticut Health Association on April 2. This was a gathering of about 300 persons, consisting of just about everyone involved in the implementation of P.L. 93-641 in Connecticut.

Also at this giant session, Andrew Johnston, representing the HEW regional office said that subarea councils would not have as much clout as the HSAs. If Connecticut opted for one HSA, his office would have to have especial assurances that community participation was assured.[90]

By the end of April, Dr. Adams had personally contacted representatives of most of the RPAs, the State Medical Society, the various CHP "B's", and NHHC. He had visited Professor Thompson at Yale three times requesting updates on his data for hospital statistics and patient origins.

As the task of determining the HSA areas in the states approached the deadline, the DHEW was beginning to anticipate some of the problems it would have with the incoming HSA designation plans:

> HEW is less than happy with the direction being taken in the designation of Health Service Areas (HSA) under the new health planning legislation. While it was anticipated that Standard Metropolitan Statistical Areas (SMSA) which crossed state boundaries would be covered by single HSAs, 33 of the 38 interstate SMSAs have requested waivers from HEW to allow the SMSAs to be broken by state boundaries. HEW, however, plans to take a hard line on approving the waivers. According to Eugene Rubel, Chief of the Bureau of Health Planning and Resources Development, 'I'll do everything I can to see that the waivers are granted sparingly and only in those cases where they make good health planning sense. Arbitrary political boundaries should not be the prime consideration when you are establishing a health planning area.'
>
> It should be noted that the Congress, the Administration and health policy leaders view successful implementation of the health planning legislation as crucial to establishment of a successful National Health Insurance program.[91]

At the same time, other Congressional actions were reaffirming its intentions for the future of P.L. 93-641.

> The House Commerce Committee has approved the Health Revenue Sharing and Health Services Act (H.R. 4925). The bill now awaits Rules Committee action clearing it for the House floor. The measure renews authority for health services grants to the states, family planning programs, Community Mental Health Centers, Migrant Health Centers and Community Health Centers. The Senate passed a bill (S. 66) that lumps the services bill together with the Nurse Training Act (H.R. 4115). In approving the services bill, the Interstate and Foreign Commerce Committee agreed to a 'conforming amendment' to bring Section 314(d) into line with the requirements of the National Health Planning and Resources Development Act of 1974 passed during the second session of the 93rd Congress last year.[92]

Concurrently, Connecticut's implementation process was continuing and by around April 22, Dr. Adams had completed his survey of the state. On May 3, 1975, Governor Grasso submitted a plan for the designation of health service areas for the state of Connecticut. Copies were sent to the Region I office of HEW as well as to the Secretary. The plan, a complete collection of the data received by the Governor and collected by Dr. Adams, consisted of three volumes of approximately 800 pages each.

On Tuesday, May 6, 1975, Governor Grasso held a press conference at which she announced her plan. She intended to create five HSAs stating, "The areas may be familiar to some." Five waivers were necessitated: two because the populations of Regions III, Eastern, and Region V, Northwestern are below the population minimum; one in order to maintain the integrity of the LNV and Milford with Region II, South Central Connecticut; and, two in order to maintain the integrity of the state border with Massachusetts at the town of Somers, and with Rhode Island at New London. Both of these Connecticut towns were part of interstate SMSAs. Except for these latter two waivers and the one intra-state SMSA waiver, the integrity of the SMSAs was largely maintained. The final map was similar to only one of the proposals submitted to Dr. Adams' staff during his data gathering period. That one was the CHP proposal, which it resembled in having

five HSAs. The governor's proposal was much more strict in adhering to the SMSA lines, than any of the suggestions, however.

Events were not to be calm, however. Within a week, an article appeared in the Hartford Courant revealing the violent reaction being received by the Governor's office. It was noted that:

> . . . strong objections are being voiced from Middlesex County and from Windham County about the proposed makeup of the large eastern health service area in which both counties are included . . . Dozens of letters objecting to the makeup of the eastern health service area have been sent to Mrs. Grasso from regional health planners, the selectman of the towns involved, physicians in the regions, area hospital leaders and regional planning boards.[93]

The proposal for the five HSAs submitted to Dr. Adams by the CHP agencies had apparently been quite well-founded on constituency support. The discrepancy between their proposal and the Governor's final designation was not being taken lightly, or passively.

On May 20, 1975, Governor Grasso sent to the Region I office of HEW as well as to the Secretary, a set of "Addendum Waiver Requests for the Health Service Area Designation Plan for the State of Connecticut." This plan proposed two additional waivers. The first involved the Hartford SMSA, asking that New Hartford be included as part of the Region V, Northwest HSA because of its ties by way of the Litchfield Hills-Northwestern CHP "B", the PSRO, the

Litchfield Hills RPA, the Council on Human Services area, and the mental health planning area. Similar reasons were given in requesting that Cromwell, East Hampton, Portland, Willington, Colchester, Columbia, and Coventry be made part of the Region III, Eastern HSA. The second additional waiver request involved the New Haven SMSA. Again, because of CHP "B" agency, PSRO, RPA, and CHS ties, Clinton and Killingworth were asked to be included as part of the Region III, Eastern HSA. Whoever drew up the original health service area designation plan for the Governor had apparently minimized the significance of these factors and, adhering more to the law and the original HEW Guidelines, had honored the SMSA lines in these areas. The injudiciousness of this approach was becoming obvious.

As a matter of fact, there was general dissatisfaction with the whole process of area designation in Connecticut. Professor Thompson remarked that outside of the three visits paid to him by Dr. Adams and his staff, there was little in the way of his patient origin data that appeared manifest in the final designation plan. Indeed, the data he and the Medical Care and Hospital Administration division at Yale had gathered together did not investigate beyond the possibilities of three HSAs.[94] Also, the nature of function of Dr. Adams' group appears to have been almost purely that of data gathering, as identifying who made the final decisions is problemmatic. Many of the colleague committee and task force

members did not know the final nature of the HSAs until the Governor's press conference.[95] The precise nature of influence on determination of the boundary lines is far from clear. Certainly, the decision to have five HSAs was based on a sound interpretation of the intent of the law and on actual community sentiments across the state. The first Connecticut proposal was pretty distant from that suggested by primary advocates of having five HSAs. That is, it differed from the CHP proposal in that it pretty much retained the SMSA lines. But the final area designation clearly has the mark of CHP influence. This may be seen on the maps included at the end of this essay.

In any case, someone had made the decisions and the political process proceeded with their modification in response to "popular demand." On Wednesday, June 18, Connectiut became one of 23 states to have its health service area designation plan approved by HEW. Of the New England states, Maine and New Hampshire also had acceptable plans while the Vermont and Rhode Island plans were yet to be studied and the Massachusetts plan was sent back for minor revisions. Technically, this was only an acceptance of Connecticut's waiver requests. Final approval would come later on August 1, 1975. All told, 201 HSAs covering 47 states were approved by HEW at that time. Of the state plans submitted, 38 were accepted without change. Nine required revisions because HEW denied waiver requests.[96]

State Agency Designation

Having designated the health service areas, Governor Grasso next had to go about designating the State Agency. This process was nothing like that for area designation. No consultations were required and there were absolutely no constraints on the decision of the state's chief executive, by law, other than that the agency be endowed with the powers and authority stipulated by P.L. 93-641.

Connecticut was privileged in its possession of a rate regulating agency, CHHC. This was one of eight such agencies planned or in operation in the country, Maryland and New Jersey having older though somewhat less active or effective agencies. Furthermore, this agency also included health planning as a part of its operations. Ostensibly, it was supposed to combine the two functions. Indeed, the Connecticut experience was studied by the staff of Congressman Roy when they were drafting legislation that eventually evolved into P.L. 93-641. Rate regulation, mandated in Senator Kennedy's Senate bill no. 2994, was only encouraged in the final law. But the financial incentive was certainly a strong one as the states headed into the second year of America's worst economic slump since the depression.

One of the most astute bureaucrats in the state, Mrs. Hirakis of the state CHP "A" agency in CHHC was addressing the question of state agency designation as early as the

February 3 meeting with the "B" agencies. Although the main concern at the time was area designation, she remarked that insofar as Connecticut was a pilot state in merging planning and regulation, CHHC work would be used as a model for HEW regulations concerning the State Agencies. Thus, she felt that the State Agency would have the greatest potential for Connecticut if placed in CHHC.[97] Later in the year, Mrs. Hirakis was asked why she had not advocated this position more actively. Her response was that machinations and agreements between the commissioners, Mr. Whitten of CHHC and Dr. Lloyd of the SHD had prompted Mr. Whitten to request that Mrs. Hirakis not make a separate statement as the "A" agency head but rather support the official CHHC position as it developed.[98] An experienced and successful bureaucrat, as attested to by her survival of the "A" agency transfer from the SHD to CHHC in 1973, she decided to obey.

In anticipation of the need for some sort of legislation in regard to authorization of powers to the State Agency, Roslyn Fishman of SCC/CHP suggested to her local legislators that preliminary action might be initiated. One of these legislators was Senatory Anthony Ciarlone (Dem., New Haven) who was co-chairman of the Committee on Public Health and Safety. Fred Hyde of the Connecticut Hospital Association and the Senator worked out Committee Bills No. 1547, an act concerning Health Planning and Resource Development Functions and Committee Bill No. 8428, an act

concerning the creation of a Statewide Health Coordinating Council. These were submitted to the Committee on Public Health and Safety on March 6, 1975. The latter bill established a statewide health coordinating council consisting of the commissioner of health, the executive director of CHHC, and five members appointed by the governor. The former bill stated that CHHC would carry out the health planning and resource development functions in accordance with sections 1522 and 1523 of P.L. 93-641. It in effect designated CHHC as the State Agency. Both bills would have been inconsistent with the specifications stated in P.L. 93-641. However, Roslyn Fishman reported to the advisory board of SCC/CHP that, "We have been advised that the intention is to get a statutory existence for SHCC and amend it later."[99] Both bills died in committee. The consensus was to defer the decision to the governor's office.

This confusion and mystery surrounding the State Agency designation process never was resolved until the governor announced her decision. Up to that finale, diversity of opinion was legion and the manner of input to the governor was obscure.

Dr. Adams himself had suggested that he would be making recommendations as to the nature of the State Agency and the SHCC. Indeed, his committee structure implied that he expected some continuity between it and the SHCC. His position on the State Agency was that a new, independent body

should be established.[100] At the Governor's press conference at which she announced her HSA designation plan, Jay Tepper, the commissioner of the Department of Finance and Control had stated that no new state funds would be involved in the implementation of P.L. 93-641.[101] Of course, this seriously mitigated against any chance that a new agency would be created.

Most of the state agencies, CRMP, and of course CHHC favored the Commission on Hospitals and Health Care for the role of State Agency. At a meeting of the Commission on May 13, the decision was made that the CHHC should begin lobbying on its own behalf with respect to State Agency designation. Dr. Lloyd, who is an ex officio member of the Commission, was silent on the issue at this meeting.[102] Dr. Cohen, (Dem., Bloomfield), co-chairman of the Committee on Public Health and Safety along with Senator Ciarlone both favored CHHC. The CHP agencies, too, went along with having CHHC become the State Agency. Also, Fred Hyde and the Connecticut Hospital Association strongly recommended that CHHC become the State Agency. In fact, from an outsider's point of view, CHHC was the logical choice.

The Governor's own Transition Staff had made comments pertinent to this issue much earlier in the year, however. One of their major findings was that health planning and development in Connecticut lacked direction. There was no clear focus or placement of responsibility for health planning

and development, they said. No one knew who spoke for the state and division of activities between the SHD and CHHC did not help this. As events were to prove, Governor Grasso took advantage of the mandate of P.L. 93-641 to try to rectify this state of affairs.

The one other agency with a large interest in the State Agency designation was, of course, the state health department. Earlier in the 1975 session of the General Assembly, the emergency medical services (EMS) of CHHC had been transferred to the SHD. One reason may have been administrative problems plaguing CHHC, as the director of the EMS section was generating a great deal of animosity among various volunteer ambulance services around the state. This problem also indicated to some, however, that an independent commission is unable to conduct development projects. In retrospect, however, the move seems to have been part of a larger plan; perhaps to consolidate the state's health activities in the areas of planning and resource development. Rosemary Johnson, the executive assistant to the commissioner of the SHD, received her MPH degree from Yale in the spring of 1975. During early 1975, she had worked with the Governor's Transition Staff, had been on Dr. Adams colleague committee and had worked with Professor Thompson at Yale on the patient origins study for Dr. Adams. She and Mr. Thompson also worked on a draft of legislation which proposed designation

of the health department as the State Agency. Portions of this draft eventually wound up as part of the final legislation which established the State Agency.

Perhaps pertinent here is an article written by Professor Thompson back in 1974, "Future Roles of Schools of Public Health in Relation to State Health Services." In it, he describes the trend of various states to attempt "control of those units of the medical care delivery system not directly involved with, and separable from, the private practice of medicine."[103] The method is often characterized by four levels of control. The first is through control of units of production by way of certificate of need legislation. The second involves review, approval or setting of charges for institutional services. The third is review and monitoring of the quality of institutional care while the fourth is the review and monitoring of the effectiveness of the medical care delivery system. This all marks the direction in which many states are moving, says Professor Thompson, that is, ". . . state agencies will become increasingly responsible for monitoring personal health services."[104]

On May 16, Governor Grasso held a preliminary discussion on this matter of State Agency designation in her office. Present were the Governor, her executive assistant, Nancy Lewinsohn, as well as her special assistant for policy and programs, Jeff Daniels. Also present were Dr. Adams,

Dr. Cohen, Dr. Lloyd and Jay Tepper. It is uncertain just exactly what transpired, but CHHC did not appear to fare well, at least in Dr. Cohen's estimation. And, indeed, it did not fare well at all in the end.

On May 22, the Governor held a press conference for the purpose of designating the state health department as the State Agency for the purposes of P.L. 93-641. To perform the required functions, she established a new Bureau of Health Planning and Development within the health department, to be administered by an appointee of the Governor. And, finally, she proposed to transfer the staff of CHHC to the state health department. Emphasizing that CHHC would remain an independent body and would retain its regulatory functions, she required that the health department would provide the staffing, planning, and statistical resources needed by the Commission. To accomplish all of this, she issued an executive order. Also, the Governor submitted enabling legislation to the General Assembly.

Though the state health department had regained the planning functions it had lost to CHHC in the Meskill administration, the actual authority of the commissioner of health in this regard was put in question by the separate gubernatorial appointment of the head of the new bureau of planning and resources development. The future of CHHC as an independent body was also put into question. Although, at the close of the 1975

legislative session it still existed and retained its regulatory function.

Overall, 1975 saw several significant changes in the operations of the state health department. As of July 1, the former office of mental retardation of the health department became a separate state department. That office had accounted for some 60% of the health department budget. The direct care of patients in the state's tuberculosis and chronic disease hospitals was reduced with most of the task being taken over by the community general hospitals and nursing homes. As mentioned, SHD had acquired responsibility for administering the EMS program which includes licensing, regulating and training ambulance crews, hospital emergency rooms and their staffs. The SHD also established a new division of health statistics. These, plus the designation as State Agency under P.L. 93-641 led to a speculation over the department's strategy and future:

> . . . the new focus is to leave many direct services to local and regional groups and have the department concentrate on gathering facts and planning coordinated programs for the communities. . . the reorganization is at least a first step by the Grasso administration to set some new missions and goals for the health department. Such guidance has been needed badly for several years because the department has lacked a clear focus of mission.[105]

The changes made with regard to CHHC were administratively very awkward, to say the least. At its July 8, 1975, meeting one of the Commissioners implied a certain amount of collusion was taking place over the appointment of an executive director for CHHC.[106] The position had been vacant since

January and the implication was that agreements had been made between the Governor, SHD, and the outgoing chairman of CHHC (as of August 3, 1975) that the selection would be deferred until a new chairman of the Commission was designated. The position of executive director, as the administrative link between CHHC and the SHD was crucial. This was especially the case considering that the executive director would establish the nature of staffing demands that CHHC would make of SHD, on which it was now totally dependent. In addition, the fact that the Commissioner of the health department was a member of the Commission on Hospitals and Health Care meant that he would have a say in the selection of the executive director and brought the nature of CHHC's independence into question. Though Dr. Cohen's CHHC was still extant, its future was certainly in doubt.

So too is the effectiveness of the State Agency. Its origins in the state of Connecticut, at least, were surrounded by a complicated morass of political considerations. The ambiguity as to its role, perhaps an intentional ambiguity, as specified under P.L. 93-641 means that its future, and therefore that of the whole program in Connecticut rests on how much or how little responsibility is placed on it by the HEW regulations. There is also very real grounds for questioning how well the agency will be able to discharge those responsibilities. Congress and HEW had certainly favored independence of the HSAs while the various governors were

pressing for an increased role and influence for the state, in the name of public accountability of the program. The outcome is unpredictable as the HEW regulations have yet to be drafted.

Health Systems Agencies

The opportunity for public input into the proposed HEW regulations for the health systems agencies occurred on April 7 and 8, 1975. This was at a meeting at the University of Massachusetts for HEW Region I, and came at the peak of activity over area designation. The schedule of events, as reported by a representative of the regional HEW office was for the draft regulations for health systems agencies designation and grant applications to be ready by July 15. Specifics on the HIPs, AIPs and state plans were to be out by November 1, guidelines and performance standards for agency operations were planned to be published by March, 1976, and all health systems agencies were to be designated by June 30, 1976. As it happens, the proposed rules for HSA designation and funding appeared in the October 17, 1975, Federal Register.

One of the major flaps over these first set of regulations arose over an issue dating back to Congressional debates on the bill which eventually became P.L. 93-641. Having already suffered through the governors' numerous waiver requests, HEW now had to confront one of the other

proponents of public accountability, the National Association of Counties:

> One of the key features of the proposed regulations is the concessions made to the National Association of Counties (NACo) and the state governments concerning the structure of, and appointment of members to HSAs. In particular, the groups were concerned over the input that they would have in the planning process and objected to earlier drafts of the regulations which would have limited their ability to influence the planning process.
>
> In order to overcome these objections, HEW emphased: (1) things that the HSA governing bodies could do, and (2) that the governors would be expected to play a significant role in selection of the HSA members. HEW would not, however, go so far as to give HSA governing bodies authority over HSA planning actions, since HEW believes this is precluded by the law.[107]

These concessions are seen especially in that section of the proposed regulations dealing with the responsibilities and authority of the governing body of the HSA, Section 122.109 (d)(1-2). These state that if the governing body of an HSA is a public regional planning body or unit of general local government, the board of such public planning body or unit of government may establish procedures for the functions of the governing body, may review its actions and may establish rules and regulations for the exercise of its responsibilities. For the most part, however, there were few constraints imposed one way or another which were not already implied in the law.

Once the regulations were out, the timetable for the application procedure was pretty tight. Dr. Gertrude Hunter of the HEW Region I office proclaimed, "All kinds of groups can participate in the planning process and can seek official designation as the regional HSA."[108] Letters of intent to file applications for HSA designation had to be received by the Governor's office by December 1, however, while the deadline for formal applications was January 19, 1976. The deadline for state review was set for February 16, 1976, at which time the Governor's recommendations were due at HEW. The official HEW selection of health systems agencies would be made by March 31, 1976.

The scramble for health systems agency designation had begun long before, however. On the day that HEW approved Connecticut's area designations, an article appeared in the New Haven Journal Courier:

> New Haven Health Care, Inc. (NHHC) has served as a successful prototype for regional Health System Agencies (HSA) which will be established this year, according to Bruce P. Arneil, chairman of the group.
>
> . . . NHHC is seen as one of three groups which will be considered for the designation as regional HSA. The others are the Connecticut Regional Medical Program (CRMP) and the South Central Connecticut Comprehensive Health Planning (SCC/CHP).

The CHP "B" agencies, the Health Planning Council of Fairfield County (Bridgeport), the Capitol Regional Health Planning Council (Hartford), as well as SCC/CHP had already assembled transition committees by this time. Things were

less efficient for the newly designated Northwestern HSAs, however. The three established CHP "B" agencies there were not terribly enthusiastic over the development. The Central Naugatuck Valley Health-Mental Health Planning Council, the Housatonic Valley Health Planning Agency and the Community Council of Northwest Connecticut were expected to pull together nevertheless, and apply for HSA designation in a combined effort.[110]

Any combined effort between CRMP, NHHC, and SCC/CHP in the South Central Connecticut region was bound to be colored by the unfortunate publicity accorded to CRMP during this period. Both CRMP and NHHC were struggling with the general impression of their programs as being strongly representative primarily of the interests of health professionals and service delivery institutions. CRMP additionally was strongly identified with the interests of the educational institutions. In fact, earlier grant applications by CRMP to HEW had met with similar criticisms from that quarter.[111] The acting director of the Department of Regional Medical Programs (DRMP) had commented in 1974 that, "CRMP is so unique that it is not understood in Washington."[112] This was in reference to CRMP's global approach to its federal mandate in combining its resources funding with an overall plan for the state, with the main thrust of its effort being directed through the two medical centers in the state. Similar criticisms were made by Governor Grasso in a letter to

DRMP in June, 1975. Responding to CRMP's grant application for funding through the second half of 1975, she wrote, "To put it bluntly, we find it difficult to understand CRMP's role in implementing P.L. 93-641."[113] This CRMP application requested over $1,000,000 to fund resource development, of which $252,400 was sought for "transition activities and program development." The Governor's impression:

> Early in the designation process, they offered the state $75,000 for the development of the area designation plan.' According to Governor Grasso, 'this offer was refused because I decided that it was important for the state to fund the project to avoid any possibility of a question of potential conflict of interest or of favoritism.'
>
> She also took issue with a claim contained in the CRMP application that the Community Studies Unit at Yale University, which would continue to be funded by $26,250 in federal funds channeled through CRMP had a key role in formulating policy for the state. . .
>
> Governor Grasso said she hoped the funds sought by CRMP for the coming fiscal year for health planning would be, '. . . funneled to the unified, coordinated state effort now forming under my explicit direction. . .' in the state health department.[114]

Earlier in April, CRMP, or at least its executive director, had rubbed the Governor the wrong way:

> Morrissey is . . . now attacking Mrs. Grasso's proposal to subdivide the state into five health planning and service areas, saying that Washington has expressed to him 'surprise and disappointment' at the five area plan. He is still seeking support of his concept to only two regions.
>
> Morrissey also proposed that Mrs. Grasso set up a new state agency to supervise all health planning and said CRMP had the 'proven track record to do it.'[115]

They also had brought criticism from the CHP "B's":

> Four of the local health planning groups have sent their objections about CRMP's $1 million budget request to Washington. . .
>
> Before the local health planning groups rejected CRMP's budget, the two groups met to discuss their differences. The planners objected to Morrissey's proposal to set aside $252,000 for 'transitional activities and program development,' another $180,000 for core staff salaries and $395,000 more for 'program staff activities.'
>
> These funds, the planners said, are not designated for specific projects. Morrissey, they said, 'could use them to further his ambitions for his agency.'[116]

In Washington, DRMP itself had received only half of its requested funds. CRMP in June received about half of its $1 million request, or $562,926. Of the total award, CRMP's executive committee and advisory board decided to hold out spending about 4/5 of it for three months, after Governor Grasso asked CRMP to defer immediate spending in order to aid the health department and the five health service regions in their development of the new health planning programs.[117] Letters of invitation to submit proposals to CRMP for development funding were sent out to the SHD, the CHPs, RPA, and the EHSDS. CRMP requested that letters of intent to submit proposals be sent before July 10, and that formal proposals for activities in making the transition to HSAs be received at CRMP by July 31. CRMP advised that its final action for funding and support would be made by its advisory board on August 28. CRMP also announced that it

would not itself seek designation as an HSA.[118] The CRMP budget was slated to run out on June 30, 1976.

While CRMP struggled to maintain some influence, the SCC/CHP was going about the business of seeking designation as an HSA. On June 3, 1975, its executive director, Roslyn Fishman, had convened the board of directors to discuss the matter of transition activities. It was decided at that time to form an official transition committee.[119] The first meeting of this committee occurred on July 14, at which time it was decided that their approach should be to examine and develop the merits of CHP as the new HSA alone instead of meeting with NHHC or CRMP. This was reported to the full SCC/CHP board of directors on July 29.[120] Following the announcement, the board passed a resolution stating the intent of SCC/HCP to file an application for HSA designation.

The August 22 meeting of the transition committee brought the news that, like CRMP, SCC/CHP would be funded through June 30, 1976. Also, it was announced that Dr. Adams had refused the position as chief of the Governor's new bureau of health planning and resources development. Finally, and very pertinent to SCC/CHP, it seems that CRMP had received a joint application from the regional council of elected officials of Southern Connecticut (RCEOSC) and the Valley council of government (VCOG) requesting funding for a project to develop an HSA application for the south central Connecticut region.[121] By August 29, the committee had had a

chance to review the application and it was decided that the design was to "cut CHP's throat."[122] The regional planning staff named in the proposal had no expertise in the field of health planning. It was also noted that the advisory group at CRMP had voted eight to six, surprisingly close, against making approval of the application conditional on the inclusion of evidence of collaboration with SCC/CHP. The decision of the SCC/CHP transition committee was to propose a meeting of the mayors and first selectmen of the area with the SCC/CHP board of directors for the purpose of finding out if the intention of the proposal was to exclude the CHP. Members of the committee, meanwhile, were urged to make contact with all the members of the RCEO and VCOG.

At the September 5 meeting of the committee, contacts had been made and it was discovered that, in fact, VCOG had not approved the application. Also, CRMP had approved $12,540 to be given to the RCEO for partial support for developing an HSA application over the period 10/1/75 to 2/29/76. One of the conditions, however, was that "engagement of SCC/CHP would characterize each step of the process.[123]

A consensus among the transition committee was reached on September 26. At that meeting, they agreed to work with the RCEO as the RCEO board had voted to support, retroactively, their development proposal which had been prepared by their staff. The committee decided, however, that their main

emphasis would continue to be to develop SCC/CHP's own program. They were also notified that the United Ways of Milford, Meriden-Wallingford, the Lower Naugatuck Valley, and New Haven did not want to alienate the RCEO and was withholding outright endorsement of any group in the HSA process. Their strategy was aimed at achieving a "share of the pie" at the end.[124] The committee decided to invite a representative of the Greater New Haven United Way to sit on the transition committee.

At their October 10 meeting, the committee received a copy of a resolution which had been adopted by the NHHC board of directors back on June 19, 1975. It stated that only one HSA designation application should be filed from the South Central Connecticut region II and that that application should be, ". . . the product of an open, community-wide process involving all interested groups."[125] The board of directors of NHHC had also delegated full authority to its executive committee to take actions on its behalf, including coordination of the work of the NHHC transition committee. The SCC/CHP committee also learned that the VCOG had never approved to be a part of the RCEO effort. The SCC/CHP committee then decided to ask that the VCOG appoint Ann LoPresti to serve on the SCC/CHP transition committee as the VCOG representative. (She was already on the SCC/CHP advisory council and board.) They also recommended to VCOG that they

have Ann LoPresti and one other person represent them on the RCEO Policy Commission and that the Valley community council be given a lead role in the whole process. (It should be noted that the president of the Lower Naugatuck Valley Community Council was Audrey Heusser, vice-chairman of the SCC/CHP transition committee.)

By the October 31 meeting of the SCC/CHP transition committee, the HEW regulations on the health systems agencies had been published. Also, on October 28, a meeting had been held in Hartford, co-sponsored by the HEW Region I office and the SHD. There it was announced that public meetings would be held in each of Connecticut's five HSAs for the purpose of explaining the law and soliciting applications. Letters of intent to file an application from interested groups would have to be received by the Governor's Office by December 1. Following that the applications would be reviewed by state and federal experts and a second round of public hearings would be held. The deadline for public notice of such hearings was December 22. The deadline for formal applications would be January 19 with state review being completed by February 16. HEW also predicted that Congress would probably fund the program at $0.25 per capita.[126] This was less than the $0.40 per capita which SCC/CHP was currently receiving.

Proceeding in its plans to file a letter of intent to apply for HSA designation by the December 1 deadline, the

SCC/CHP transition committee met again on November 7. Roslyn Fishman informed them that, ". . . the only commitment that can be asked of NHHC or other such agencies at this point is that they not file separate letters of intent."[127]

By way of contrast, the Health Planning Council in the Hartford and New Britain-Bristol Region IV had already scheduled public hearings to inform and get the input of people about the law and its intent to file an application. It had also scheduled a regional public hearing on its application for December 18.

Back in stormy Region II, SCC/CHP continued in its struggle to put together its application. By November 14, 1975, the chairman of SCC/CHP, Marcus McCraven and Roslyn Fishman had met several times with NHHC's executive director Larry DeNardis and Courtland Wilson, chairman of their transition committee. A list of the NHHC committee is included in Appendix C. An agreement was reached whereby the CHP agency would be the applicant for HSA designation and NHHC would be a co-sponsor with its staff providing assistance. NHHC representatives would be included on the SCC/CHP transition committee. Also, the day before, Roslyn Fishman had met with the Association of Community Health Service Agencies (the home-health services association) in the presence of Dr. Lloyd and Andrew Johnston of the HEW Region I office. It was agreed that Margaret Benton would represent them on SCC/CHP's transition committee.[128]

That the New Haven County Medical Association had sent a letter of endorsement for SCC/CHP to become the HSA for the area was also announced.

Also of significance, Marcus McCraven announced to the committee that the Connecticut Hospital Association (CHA) had proposed bringing together SCC/CHP, NHHC, CRMP, and RCEO/VCOG with the SHD and HEW in order to organize a coordinating committee for the whole region to insure input from all factions. Then, under CHA sponsorship, the committee would apply for HSA designation. CHA proposed to appoint seven members of the coordinating committee. The SCC/CHP transition committee concurred that the consumer majority and composition of its own transition committee more closely resembled the intent of the law than the proposed one and that CHA's vested interest might be in conflict with that intent.

Additionally, at the November 14 meeting, its structure and organization subcommittee presented a proposed model for the HSA to the transition committee. This called for a large governing body, to insure maximum participation and an executive committee with a maximum of 25 members. These would be distributed between 11 provider slots and 14 consumer slots.

This model was unanimously approved by the transition committee at the November 21 meeting.[129] By this time VCOG had unanimously voted to support SCC/CHP as the HSA for

Region II. The structure and organization subcommittee was increased in number at this meeting to include four representatives from NHHC. The composition of the original SCC/CHP transition committee with an addendum following its juncture with the NHHC group is included in Appendix C. Also presented was the draft of the letter of intent to apply for HSA designation. At the suggestion of Andrew Johnston, this letter proposed $50,000 in local support. A federal match for this amount plus the basic predicted HSA funding of 26¢ per capita (pop. 604,300) would give the new body $157,118 in federal funding, still below its current $241,720 based on 40¢ per capita. Considering the 25% local match under the old system, the agency would go from its current $293,150 to $207,118 unless Congress increased the per capita funds. The committee voted to proceed with the letter of intent which included proposals for 12 professional staff. It currently has 10. In other words, SCC/CHP planned to do more with more people, with less money. Also noted at this meeting was the failure of the Meriden-Wallingford CHP "B" agency to co-sponsor the SCC/CHP application.

On December 1, SCC/CHP filed a letter of intent in coalition with NHHC and the RCEO to apply for HSA designation for Region II, with the Governor's office. In the North central Region IV, the Health Planning Council, Inc. the CHP "B" for the area, filed a letter. In the Southwestern

Region I, a combination of the Bridgeport CHP "B" and the Fairfield County Medical Association filed a letter. The letter of intent for the Northwestern Region V was a combination of the Housatonic Valley and Central Naugatuck Valley "B's" and the Community Council of Northwest Connecticut. The United Way of Southeastern Connecticut filed a letter for the Eastern Region III.[130] This letter was joined later by a competing letter from a coalition of the Midstate Estuary Health Planning "B" agency, the Emergency Medical Services Council of the Northeast, and community action and consumer groups.[131]

At its December 5 meeting, the SCC/CHP transition committee wrestled with the problem of representation for the HSA governing body. It decided to create two subarea councils, one for the Lower Naugatuck Valley and one for the Meriden-Wallingford area. In considering the proposal of the structure and organization subcommittee in the consumer category, it added two slots for anti-poverty group representation, and noted that of the four slots for racial minority representatives, one should be from the LNV and one from the Meriden-Wallingford NAACP. Among the providers, it clarified that there would be one slot each for MDs, nurses, dentists, podiatrists, pharmacists, optometrists, and one to rotate among chiropractors, physician assistants, osteopaths, and veterinarians. Slots for allied health professionals

were increased to two. And ex officio seats for government agencies such as the state department of social services and the social services administration were added.[132]

On December 16, 1975, the public was invited to a meeting of the advisory council of the SCC/CHP. In total, the governing body of the HSA was proposed to have 103 members with 59 consumers (57%) and 44 providers (43%). Also five would be elected officials, two from the RCEO of South Central Connecticut, one from the VCOG, and the state representative and senator from South Central Connecticut. Further categories among consumers included representatives of business and industry, the elderly, anti-poverty groups, labor, linguistic groups, racial groups, and private agencies. Among providers were to be the health professionals (7) as just described, health care institutions (4), health care insurers (2), health professional schools (2), black health professionals (2), allied health professionals (2), public agencies concerned with health (3), Veterans Administration (1), health maintenance organizations (1), PSRO (1), CRMP (1), NHHC (1), SCC/CHP (1), Meriden-Wallingford CHP (1), and others.[133]

At the December 19 meeting, it was announced to the transition committee that the LNV Regional Planning Agency voted unanimously to recommend SCC/CHP's application for HSA in Region II. It was also proposed to add a slot on the governing body for an anti-poverty group from Milford and a

representative of CHA wanted to increase the slots for community hospitals from one to three to include representation from the LNV, Milford, and Meriden-Wallingford.[134] As of the end of the year, the SCC/CHP application called for a governing body of 112 and an executive committee of 25 to have a structure and organization as determined by the governing body. It also proposed a staff of 14 professional planners. Such was the status of the application going into the public hearing scheduled for January 5, 1976.

Analysis

The events of 1975 in Connecticut reflected the combined impact of federal legislation, the historical background of the Connecticut health planning system and the peculiar political forces at work during the year.

Notable developments were:

1. The original health service area designation did not really represent the spectrum of input except that the decision was made to create more rather than fewer areas. The final decision maker was unclear, as was the rationale upon which the decision was based.
2. The final area designation is suggestive of either the power or representativeness of the broad-based constituent makeup of the CHP program.
3. The wisdom of the old study establishing the hospital service areas, which became first

the CHPs then the HSAs probably lay in its congruence with the state and local governmental regional planning areas. The difficulty of getting away from this basis for dividing the state is also apparent, as are the political forces which make this so.

4. The decision-making process for selecting the State Agency was really no more or less "open" than the more complex method of selecting the HSAs and was probably just as dependent upon unseen forces influencing the Governor and her delegates.
5. The influence of study groups at Yale seems to have been significant in both decisions.
6. The consumer dominated agencies enjoyed more popular support and seem to be destined to play a larger role while provider dominated agencies, specifically CRMP, CHA, the state medical society and PSROs, were struggling to have an influence on the outcome of events.
7. The political forces acting on the area of health planning played a part in area designation, State Agency designation, and in the efforts to establish an agency in South Central Connecticut. In all phases of implementation of the law, much time

and effort is spent on being in the right place, at the right time, with the right support in efforts to be heard by and to have influence upon the decision makers.

8. As a corollary to the highly political environment in Connecticut's health planning system, much time, effort and resources of the system is spent on bureaucratic attempts of agencies to survive and retain influence.
9. Initiatives and innovations in attempts to improve planning, resource development, and regulatory activities can take place independently at federal, state, and local levels. Such is the nature of the system that isolated good results or intentions at the local (CRMP successes in combining planning with resource development), state (CHHC regulatory activities) and federal (P.L. 93-641) do not always have salutory results when such efforts are channeled from one level to affect the others.
10. The conflict between Congress/HEW and the States over power and influence can have a detrimental effect on the organization and effectiveness of the health planning system.

11. Despite the bureaucratic complexity, the broad constituency and community orientation of the HSAs can give them even more political "clout" than the CHPs had in Connecticut, for example, during implementation of P.L. 93-641 in the South Central Connecticut region.

12. The Connecticut experience in 1975 suggests that no matter how accurate federal impressions of shortcomings in a system are, the specification of actions designed to rectify those shortcomings may, in individual states, have a detrimental effect by precipitating retrenchment of innovations and re-exposing the system to political forces and interests. That is to say, state and local political forces can create innovative institutions and policies as well as regressive or ineffective ones. Once these become fixed and, in a sense, protected, as a bureaucratic organization, any attempts to make sweeping changes in the system will once again expose both good and bad aspects of the system to the full range of vested interests and political influences. And the result is not predictable. For example, though Congressional intent may have been for the pre-existing CHPs to evolve into the

HSAs, the experience of SCC/CHP demonstrates that compromises and political interactions become involved in such an "evolution." And, again, though Connecticut's CHHC was obviously the logical designee for State Agency, and indeed, was a model for the federal legislation, events determined that this transition did not occur.

DISCUSSION AND CONCLUSION

This essay has noted the nature of the political ingredient in the changes which took place in the health planning system in Connecticut in 1975. The political forces behind the passage of a piece of federal legislation are both representative of and effective upon the state and local systems. Activities at the state level likewise can influence federal actions both to suggest innovation as well as to color legislative intent with idiosyncratic political concerns during implementation. Local activities can have similar effects, to a very large and real extent, on both federal and state actions. The activities of CHPs, CRMP, and the Yale study groups are specific and significant examples.

Although the nature of vested interests and strategies are predictable, and overall policy can be discerned by a distant and dispassionate analysis, the final outcome, indeed, the nature of the process which determines the outcome, is infinitely dependent upon the personalities, energies, motivations, actions, and timing of the individuals who comprise the system. As aptly stated by Herman Hesse in the quote at the beginning of this essay, the system is a living body composed of parts, each of which has its own

nature and freedom. It is this ingredient of the health planning system which makes it political. It is this which makes its success dependent upon interaction and communication between individuals. These are the principles by which the system operates. The attempt was made here to demonstrate the organizational and operational nature of these principles with identification of some specific interests, organizations, and personalities.

Finally, there is need to focus on such specifics if there is to be any understanding of events. There is no political system that does not have specific goals and specific organizations and persons involved to give it its peculiar and unique coloration. Money is always involved. In Connecticut, CRMP had it, while the CHPs did not. Yet the CHPs survived while CRMP is in the process of fading away. Also involved in this particular political system is the future health of the nation. That is to say, Roslyn Fishman, Fred Hyde, Rosemary Johnson, Professor Thompson, Commissioner Lloyd, Governor Grasso, and perhaps Dr. Adams, along with the RCEOSC, VCOG, the anti-poverty groups, and the Meriden NAACP and scores of others will all be involved in trying to gain increased leverage in the decision making process for developing, financing, and regulating the medical care system. But all this further calls into question some very basic aspects of the private enterprise system and the nature of the medical profession, nature and [illegible]

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which was not really involved in any of the decisions discussed here. The nature of their future participation and response will be crucial. In this particular system, there is also a calling into question of the principles of the federal system of government. Already, Governor Grasso's unique response has colored the future of the HSA program in Connecticut.

Only by understanding these specific issues as well as the general principles of political interaction can understanding be gained as to why and how the American health system will continue to evolve:

> HEW's enthusiasm for HSAs stems from several sources, but the economizing potential is a most agreeable one for the budget makers of the Department. In that regard, they are in full harmony with the members of Congress who write legislation for health affairs, and therefore, no barriers exist to the addition of HSAs to the framework of federal authority over medicine. In deference to the tradition of local control, the HSAs will operate at some distance from direct federal authority but the most powerful influence on their decision-making will be located in Washington, and as health costs inexorably rise, and the federal government is required to help meet them it is only reasonable to assume that the HSAs will lose rather than gain independence, while growing ever more powerful in the affairs that HEW entrusts to their care.135

The political nature of the existing system both allows for input from all interested parties and, indeed, it can also be seen to require such universal participation if it is to be successful. Weaknesses and failings of the health care delivery system have been perceived by the people and their

government and have precipitated increasing governmental and public involvement in the activities of this sector. Since the structure and authority given to the agencies and organizations which constitute such public involvement is based on the assumption that decisions will reflect a pluralistic input, this system can only be effective if such a pluralistic input is meaningfully achieved. By identifying the particular people, interests, and organizations involved in Connecticut, an understanding can be gained as to how these forces of evolution get translated into results. This is the explanation for why and how Connecticut changed its health planning system in 1975.

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APPENDICES

APPENDIX A: THESIS PROPOSAL

APPENDIX B: PUBLIC LAW 93-641

APPENDIX C: THE CONNECTICUT HEALTH PLANNING SYSTEM

APPENDIX D: GOVERNOR'S SYSTEM

APPENDIX E: DR. ADAM'S SYSTEM

APPENDIX F: MAPS

March 17, 1975

Proposal for M.D. Thesis
David Kawanishi

Subject: Implementation of federal law PL 93-641, the National Health Planning and Resources Development Act of 1974 in the State of Connecticut. This will be a policy study from the point of view of implementation rather than policy formation. Pertinent aspects of the formation of this policy will have to be identified, however, in order to provide the conceptual continuity of forces necessary for an understanding of implementation. The focus will be on the State of Connecticut with primary emphasis on the nature of activities of the Governor's special committee under the direction of Dr. Frederick Adams. The format will be similar to that employed by Rosemary Stevens and Robert Stevens in their study, Welfare Medicine in America, a study of the implementation of Medicare and Medicaid. The scale will be smaller, of course.

Materials and Methods: Data will be gathered by way of personal interview, media review, review of pertinent statutes and regulations, review of pertinent legislative hearings at both the federal and state level, study of existing state and federal agencies, analysis of past efforts pertinent to health care planning, and, as necessary, a review of social, political, and economic theory. Sources will be pertinent individuals, as limited by access to them, the media, State and federal statutes and codes, published accounts of Congressional and General Assembly hearings, available legislative newsletters, and guidelines and recommendations as issued by HEW, again, as limited by access to them. Offers of guidance and instruction have been received from Rosemary Stevens, Ph.D., David Warner, Ph.D., both of the Institute of Social and Policy Studies of Yale University, and George Silver, M.D., and James Bjorkman, Ph.D., of the School of Epidemiology and Public Health of Yale University.

Results: Expected results consist of a documented chronology of the important events in the implementation of PL 93-641 with respect to the issuance of instructions by HEW, and the method of determination of Health Systems Area boundaries and councils, the selection of the State Agency and the granting of powers to it, and the formation of the Statewide Health Coordinating Councils, all limited to the State of Connecticut. Hopefully, the documentation will also include identification and nature of participation of the principle actors and organizations. As a byproduct, pertinent background and working papers will have to be generated.

Discussion: The attempt will be made to avoid trying to fit the results into any specific scheme or model of social, political, or economic behavior. Rather, the point of view will be primarily descriptive. Identification of the important actors and forces will be made as clear as possible. Social, political, and economic theory will be employed only in attempts to achieve this end. Hopefully, this identification of factors can be done to such an extent that it will be possible to correlate them with other recent studies and then reknit them in an attempt to understand the complex fabric of the politics of health care in America.

Timetable: The deadline for Health Systems Area boundary determinations is May 3, 1975. The Governor must submit her recommendations to the Secretary of HEW by that date. Collection of data and the generation of working papers has already begun. Collection of data for this study is expected to continue beyond that time, through the summer to around early September. The intensity of this activity, particularly during the period June through August, will largely be determined by financial resources available to this researcher. Although it is difficult to estimate at this time, it is expected that the depth and value of this study may rest largely on the availability of resources during this summer. The final report is expected to be completed by mid-December, 1975. The deadline for submission of the M.D. thesis is March, 1976.

APPENDIX B: PUBLIC LAW 93-641

Public Law 93-641
93rd Congress, S. 2994
January 4, 1975

An Act

To amend the Public Health Service Act to assure the development of a national health policy and of effective State and area health planning and resources development programs, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

National Health Planning and Resources Development Act of 1974.
42 USC 300k note.

SHORT TITLE; TABLE OF CONTENTS

SECTION 1. This Act may be cited as the "National Health Planning and Resources Development Act of 1974".

TABLE OF CONTENTS

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"TITLE XV—NATIONAL HEALTH PLANNING AND DEVELOPMENT

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"Sec. 1501. National guidelines for health planning.
"Sec. 1502. National health priorities.
"Sec. 1503. National Council on Health Planning and Development.

"PART B—HEALTH SYSTEMS AGENCIES

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"TITLE XVI—HEALTH RESOURCES DEVELOPMENT

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"Sec. 1602. General regulations.
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"Part B—Allotments

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"Part D—Project Grants

"Sec. 1625. Project grants.

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"Part F—Area Health Services Development Funds

"Sec. 1640. Area health services development funds."
Sec. 5. Miscellaneous and transitional provisions.
Sec. 6. Advisory committees.
Sec. 7. Agency reports.
Sec. 8. Technical amendment.

FINDINGS AND PURPOSE

42 USC 300k. Sec. 2. (a) The Congress makes the following findings:

(1) The achievement of equal access to quality health care at a reasonable cost is a priority of the Federal Government.

(2) The massive infusion of Federal funds into the existing health care system has contributed to inflationary increases in the cost of health care and failed to produce an adequate supply or distribution of health resources, and consequently has not made possible equal access for everyone to such resources.

(3) The many and increasing responses to these problems by the public sector (Federal, State, and local) and the private sector have not resulted in a comprehensive, rational approach to the present—

(A) lack of uniformly effective methods of delivering health care;

(B) maldistribution of health care facilities and manpower; and

(C) increasing cost of health care.

(4) Increases in the cost of health care, particularly of hospital stays, have been uncontrollable and inflationary, and there are presently inadequate incentives for the use of appropriate alternative levels of health care, and for the substitution of ambulatory and intermediate care for inpatient hospital care.

(5) Since the health care provider is one of the most important participants in any health care delivery system, health policy must address the legitimate needs and concerns of the provider if it is to achieve meaningful results; and, thus, it is imperative that the provider be encouraged to play an active role in developing health policy at all levels.

(6) Large segments of the public are lacking in basic knowledge regarding proper personal health care and methods for effective use of available health services.

(b) In recognition of the magnitude of the problems described in subsection (a) and the urgency placed on their solution, it is the purpose of this Act to facilitate the development of recommendations for a national health planning policy, to augment areawide and State planning for health services, manpower, and facilities, and to authorize financial assistance for the development of resources to further that policy.

REVISION OF HEALTH PLANNING PROGRAMS UNDER THE PUBLIC HEALTH SERVICE ACT

Sec. 3. The Public Health Service Act is amended by adding at the end the following new title: 42 USC 20 note.

"TITLE XV—NATIONAL HEALTH PLANNING AND DEVELOPMENT

"Part A—National Guidelines for Health Planning

"NATIONAL GUIDELINES FOR HEALTH PLANNING

"Sec. 1501. (a) The Secretary shall, within eighteen months after the date of the enactment of this title, by regulation issue guidelines concerning national health planning policy and shall, as he deems appropriate, by regulation revise such guidelines. Regulations under this subsection shall be promulgated in accordance with section 553 of title 5, United States Code. 42 USC 300

"(b) The Secretary shall include in the guidelines issued under subsection (a) the following:

"(1) Standards respecting the appropriate supply, distribution, and organization of health resources.

"(2) A statement of national health planning goals developed after consideration of the priorities, set forth in section 1502, which goals, to the maximum extent practicable, shall be expressed in quantitative terms.

"(c) In issuing guidelines under subsection (a) the Secretary shall consult with and solicit recommendations and comments from the health systems agencies designated under part B, the State health planning and development agencies designated under part C, the Statewide Health Coordinating Councils established under part C, associations and specialty societies representing medical and other health care providers, and the National Council on Health Planning and Development established by section 1503. Post, p. 22 Post, p. 22

"NATIONAL HEALTH PRIORITIES

"Sec. 1502. The Congress finds that the following deserve priority consideration in the formulation of national health planning goals and in the development and operation of Federal, State, and area health planning and resources development programs: 42 USC 300k-

"(1) The provision of primary care services for medically underserved populations, especially those which are located in rural or economically depressed areas.

institutional health services (including obstetric, pediatric, emergency medical, intensive and coronary care, and radiation therapy services).

"(3) The development of medical group practices (especially those whose services are appropriately coordinated or integrated with institutional health services), health maintenance organizations, and other organized systems for the provision of health care.

"(4) The training and increased utilization of physician assistants, especially nurse clinicians.

"(5) The development of multi-institutional arrangements for the sharing of support services necessary to all health service institutions.

"(6) The promotion of activities to achieve needed improvements in the quality of health services, including needs identified by the review activities of Professional Standards Review Organizations under part B of title XI of the Social Security Act.

2 USC 1320c.

"(7) The development by health service institutions of the capacity to provide various levels of care (including intensive care, acute general care, and extended care) on a geographically integrated basis.

"(8) The promotion of activities for the prevention of disease, including studies of nutritional and environmental factors affecting health and the provision of preventive health care services.

"(9) The adoption of uniform cost accounting, simplified reimbursement, and utilization reporting systems and improved management procedures for health service institutions.

"(10) The development of effective methods of educating the general public concerning proper personal (including preventive) health care and methods for effective use of available health services.

"NATIONAL COUNCIL ON HEALTH PLANNING AND DEVELOPMENT

stablishment.
2 USC 300k-3.

"SEC. 1503. (a) There is established in the Department of Health, Education, and Welfare an advisory council to be known as the National Council on Health Planning and Development (hereinafter in this section referred to as the 'Council'). The Council shall advise, consult with, and make recommendations to, the Secretary with respect to (1) the development of national guidelines under section 1501, (2) the implementation and administration of this title and title XVI, and (3) an evaluation of the implications of new medical technology for the organization, delivery, and equitable distribution of health care services.

, p. 2251.

mbership.

"(b)(1) The Council shall be composed of fifteen members. The Chief Medical Director of the Veterans' Administration, the Assistant Secretary for Health and Environment of the Department of Defense, and the Assistant Secretary for Health of the Department of Health, Education, and Welfare shall be nonvoting ex officio members of the Council. The remaining members shall be appointed by the Secretary and shall be persons who, as a result of their training, experience, or attainments, are exceptionally well qualified to assist in carrying out the functions of the Council. Of the voting members, not less than five shall be persons who are not providers of health services, not more than three shall be officers or employees of the Federal Government, not less than three shall be members of governing bodies of health systems agencies designated under part B, and not less than three shall be members of Statewide Health Coordinating Councils under section 1524. The two major political parties shall have equal representation among the voting members on the Council.

Post, p.

Terms of office.

"(2) The term of office of voting members of the Council shall be six years, except that—

"(A) of the members first appointed to the Council, four shall be appointed for terms of two years and four shall be appointed for terms of four years, as designated by the Secretary at the time of appointment; and

"(B) any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed only for the remainder of such term.

A member may serve after the expiration of his term until his successor has taken office.

"(3) The chairman of the Council shall be selected by the voting members from among their number. The term of office of the chairman of the Council shall be the lesser of three years or the period remaining in his term of office as a member of the Council.

Compensati

"(c)(1) Except as provided in paragraph (2), the members of the Council shall each be entitled to receive the daily equivalent of the annual rate of basic pay in effect for grade GS-18 of the General Schedule for each day (including traveltime) during which they are engaged in the actual performance of duties vested in the Council.

5 USC 5332 and note.

"(2) Members of the Council who are full-time officers or employees of the United States shall receive no additional pay on account of their service on the Council.

Travel expenses.

"(3) While away from their homes or regular places of business in the performance of services for the Council, members of the Council shall be allowed travel expenses, including per diem in lieu of subsistence, in the same manner as persons employed intermittently in the Government service are allowed expenses under section 5703(b) of title 5, United States Code.

Experts and consultants.

"(d) The Council may appoint, fix the pay of, and prescribe the functions of such personnel as are necessary to carry out its functions. In addition, the Council may procure the services of experts and consultants as authorized by section 3109 of title 5, United States Code, but without regard to the last sentence of such section.

5 USC app. I

"(e) The provisions of section 14(a) of the Federal Advisory Committee Act shall not apply with respect to the Council.

"PART B—HEALTH SYSTEMS AGENCIES

"HEALTH SERVICE AREAS

Establishmen
42 USC 300l.

"SEC. 1511. (a) There shall be established, in accordance with this section, health service areas throughout the United States with respect to which health systems agencies shall be designated under section 1515. Each health service area shall meet the following requirements:

Requirements.

"(1) The area shall be a geographic region appropriate for the effective planning and development of health services, determined on the basis of factors including population and the availability of resources to provide all necessary health services for residents of the area.

"(2) To the extent practicable, the area shall include at least one center for the provision of highly specialized health services.

“(3) The area, upon its establishment, shall have a population of not less than five hundred thousand or more than three million; except that—

“(A) the population of an area may be more than three million if the area includes a standard metropolitan statistical area (as determined by the Office of Management and Budget) with a population of more than three million, and

“(B) the population of an area may—

“(i) be less than five hundred thousand if the area comprises an entire State which has a population of less than five hundred thousand, or

“(ii) be less than—

“(I) five hundred thousand (but not less than two hundred thousand) in unusual circumstances (as determined by the Secretary), or

“(II) two hundred thousand in highly unusual circumstances (as determined by the Secretary).

if the Governor of each State in which the area is located determines, with the approval of the Secretary, that the area meets the other requirements of this subsection.

USC 1320c-1.

“(4) To the maximum extent feasible, the boundaries of the area shall be appropriately coordinated with the boundaries of areas designated under section 1152 of the Social Security Act for Professional Standards Review Organizations, existing regional planning areas, and State planning and administrative areas. The boundaries of a health service area shall be established so that, in the planning and development of health services to be offered within the health service area, any economic or geographic barrier to the receipt of such services in nonmetropolitan areas is taken into account. The boundaries of health service areas shall be established so as to recognize the differences in health planning and health services development needs between nonmetropolitan and metropolitan areas. Each standard metropolitan statistical area shall be entirely within the boundaries of one health service area, except that if the Governor of each State in which a standard metropolitan statistical area is located determines, with the approval of the Secretary, that in order to meet the other requirements of this subsection a health service area should contain only part of the standard metropolitan statistical area, then such statistical area shall not be required to be entirely within the boundaries of such health service area.

“(b)(1) Within thirty days following the date of the enactment of this title, the Secretary shall simultaneously give to the Governor of each State written notice of the initiation of proceedings to establish health service areas throughout the United States. Each notice shall contain the following:

“(A) A statement of the requirement (in subsection (a)) of the establishment of health service areas throughout the United States.

“(B) A statement of the criteria prescribed by subsection (a) for health service areas and the procedures prescribed by this subsection for the designation of health service area boundaries.

“(C) A request that the Governor receiving the notice (i) designate the boundaries of health service areas within his State, and, where appropriate and in cooperation with the Governors of adjoining States, designate the boundaries within his State of health service areas located both in his State and in adjoining States, and (ii) submit (in such form and manner as the Secretary shall specify) to the Secretary, within one hundred and twenty days of the date of enactment of this title, such boundary designations together with comments, submitted by the entities referred to in paragraph (2), with respect to such designations.

At the time such notice is given under this paragraph to each Governor, the Secretary shall publish as a notice in the Federal Register a statement of the giving of his notice to the Governor and the criteria and procedures contained in such notice.

Publication in Federal Register.

“(2) Each State's Governor shall in the development of boundaries for health service areas consult with and solicit the views of the chief executive officer or agency of the political subdivisions within the State, the State agency which administers or supervises the administration of the State's health planning functions under a State plan approved under section 314(a), each entity within the State which has developed a comprehensive regional, metropolitan, or other local area plan or plans referred to in section 314(b), and each regional medical program established in the State under the title IX.

42 USC 246.

42 USC 299.

“(3)(A) Within two hundred and ten days after the date of enactment of this title the Secretary shall publish as a notice in the Federal Register the health service area boundary designations. The boundaries for health service areas submitted by the Governors shall, except as otherwise provided in subparagraph (B), constitute upon their publication in the Federal Register the boundaries for such health service areas.

Publication in Federal Register.

“(B)(i) If the Secretary determines that a boundary submitted to him for a health service area does not meet the requirements of subsection (a), he shall, after consultation with the Governor who submitted such boundary, make such revision in the boundary for such area (and as necessary in the boundaries for adjoining health service areas) as may be necessary to meet such requirements and publish such revised boundary (or boundaries); and the revised boundary (or boundaries) shall upon publication in the Federal Register constitute the boundary (or boundaries) for such health service area (or areas). The Secretary shall notify the Governor of each State in which is located a health service area whose boundary is revised under this clause of the boundary revision and the reasons for such revision.

Boundary revision; publication in Federal Register.

“(ii) In the case of areas of the United States not included within the boundaries for health service areas submitted to the Secretary as requested under the notice under paragraph (1), the Secretary shall establish and publish in the Federal Register health service area boundaries which include such areas. The Secretary shall notify the Governor of each State in which is located a health service area the boundary for which is established under this clause of the boundaries established. In carrying out the requirement of this clause, the Secretary may make such revisions in boundaries submitted under subparagraph (A) as he determines are necessary to meet the requirement of subsection (a) for the establishment of health service areas throughout the United States.

Other health service area publication in Federal Register.

“(4) The Secretary shall review on a continuing basis and at the request of any Governor or designated health systems agency the appropriateness of the boundaries of the health service areas established under paragraph (3) and, if he determines that a boundary for a health service area no longer meets the requirements of subsection (a), he may revise the boundaries in accordance with the procedures prescribed by paragraph (3)(B)(i) for the establishment of boundaries of health service areas which include areas not included in boundaries submitted by the Governors. If the Secretary acts on his

Review.

with the Governor of the appropriate State or States, the entities referred to in paragraph (2), the appropriate health systems agency or agencies designated under part B and the appropriate Statewide Health Coordinating Council established under part C. A request for boundary revision shall be made only after consultation with the Governor of the appropriate State or States, the entities referred to in paragraph (2), the appropriate designated health systems agencies, and the appropriate established Statewide Health Coordinating Council and shall include the comments concerning the revision made by the entities consulted in requesting the revision.

t, p. 2232.

t, p. 2242.

"(5) Within one year after the date of the enactment of this title the Secretary shall complete the procedures for the initial establishment of the boundaries of health service areas which (except as provided in section 1535) include the geographic area of all the States.

t, p. 2256.

"(c) Notwithstanding any other requirement of this section, an area—

"(1) for which has been developed a comprehensive regional, metropolitan area, or other local area plan referred to in section 314(b), and

USC 246.

"(2) which otherwise meets the requirements of subsection (a), shall be designated by the Secretary as a health service area unless the Governor of any State in which such area is located, upon a finding that another area is a more appropriate region for the effective planning and development of health resources, waives such requirement.

"HEALTH SYSTEMS AGENCIES

USC 300l-1.

"SEC. 1512. (a) DEFINITION.—For purposes of this title, the term 'health systems agency' means an entity which is organized and operated in the manner described in subsection (b) and which is capable, as determined by the Secretary, of performing each of the functions described in section 1513. The Secretary shall by regulation establish standards and criteria for the requirements of subsection (b) and section 1513.

ndards criteria.

"(b)(1) LEGAL STRUCTURE.—A health systems agency for a health service area shall be—

"(A) a nonprofit private corporation (or similar legal mechanism such as a public benefit corporation) which is incorporated in the State in which the largest part of the population of the health service area resides, which is not a subsidiary of, or otherwise controlled by, any other private or public corporation or other legal entity, and which only engages in health planning and development functions;

"(B) a public regional planning body if (i) it has a governing board composed of a majority of elected officials of units of general local government or it is authorized by State law (in effect before the date of enactment of this subsection) to carry out health planning and review functions such as those described in section 1513, and (ii) its planning area is identical to the health service area; or

"(C) a single unit of general local government if the area of the jurisdiction of that unit is identical to the health service area.

A health systems agency may not be an educational institution or operate such an institution.

"(2) STAFF.—

"(A) EXPERTISE.—A health systems agency shall have a staff which provides the agency with expertise in at least the following: (i) Administration, (ii) the gathering and analysis of data, (iii) health planning, and (iv) development and use of health resources. The functions of planning and of development of health resources shall be conducted by staffs with skills appropriate to each function.

"(B) SIZE AND EMPLOYMENT.—The size of the professional staff of any health systems agency shall be not less than five, except that if the quotient of the population (rounded to the next highest one hundred thousand) of the health service area which the agency serves divided by one hundred thousand is greater than five, the minimum size of the professional staff shall be the lesser of (i) such quotient, or (ii) twenty-five. The members of the staff shall be selected, paid, promoted, and discharged in accordance with such system as the agency may establish, except that the rate of pay for any position shall not be less than the rate of pay prevailing in the health service area for similar positions in other public or private health service entities. If necessary for the performance of its functions, a health systems agency may employ consultants and may contract with individuals and entities for the provision of services. Compensation for consultants and for contracted services shall be established in accordance with standards established by regulation by the Secretary.

Consultants and contract services.

"(3) GOVERNING BODY.—

"(A) IN GENERAL.—A health systems agency which is a public regional planning body or unit of general local government shall, in addition to any other governing body, have a governing body for health planning, which is established in accordance with subparagraph (C), which shall have the responsibilities prescribed by subparagraph (B), and which has exclusive authority to perform for the agency the functions described in section 1513. Any other health systems agency shall have a governing body composed, in accordance with subparagraph (C), of not less than ten members and of not more than thirty members, except that the number of members may exceed thirty if the governing body has established another unit (referred to in this paragraph as an 'executive committee') composed, in accordance with subparagraph (C), of not more than twenty-five members of the governing body and has delegated to that unit the authority to take such action (other than the establishment and revision of the plans referred to in subparagraph (B)(ii)) as the governing body is authorized to take.

"(B) RESPONSIBILITIES.—The governing body—

"(i) shall be responsible for the internal affairs of the health systems agency, including matters relating to the staff of the agency, the agency's budget, and procedures and criteria (developed and published pursuant to section 1532) applicable to its functions under subsections (e), (f), and (g) of section 1513;

Post, p. 2251.

"(ii) shall be responsible for the establishment of the health systems plan and annual implementation plan required by section 1513(b);

"(iii) shall be responsible for the approval of grants and contracts made and entered into under section 1513(c)(3);

Grants and contracts, approval.

"(iv) shall be responsible for the approval of all actions taken pursuant to subsections (e), (f), (g), and (h), of section 1513;

"(v) shall (I) issue an annual report concerning the activities of the agency, (II) include in that report the health

Report.

plan and annual implementation plan developed by the agency, and a listing of the agency's income, expenditures, assets, and liabilities, and (III) make the report readily available to the residents of the health service area and the various communications media serving such area;

"(vi) shall reimburse its members for their reasonable costs incurred in attending meetings of the governing body;

"(vii) shall meet at least once in each calendar quarter of a year and shall meet at least two additional times in a year unless its executive committee meets at least twice in that year; and

"(viii) shall (I) conduct its business meetings in public, (II) give adequate notice to the public of such meetings, and (III) make its records and data available, upon request, to the public.

The governing body (and executive committee (if any)) of a health systems agency shall act only by vote of a majority of its members present and voting at a meeting called upon adequate notice to all of its members and at which a quorum is in attendance. A quorum for a governing body and executive committee shall be not less than one-half of its members.

"(C) COMPOSITION.—The membership of the governing body and the executive committee (if any) of an agency shall meet the following requirements:

"(i) A majority (but not more than 60 per centum of the members) shall be residents of the health service area served by the entity who are consumers of health care and who are not (nor within the twelve months preceding appointment been) providers of health care and who are broadly representative of the social, economic, linguistic and racial populations, geographic areas of the health service area, and major purchasers of health care.

"(ii) The remainder of the members shall be residents of the health service area served by the agency who are providers of health care and who represent (I) physicians (particularly practicing physicians), dentists, nurses, and other health professionals, (II) health care institutions (particularly hospitals, long-term care facilities, and health maintenance organizations), (III) health care insurers, (IV) health professional schools, and (V) the allied health professions. Not less than one-third of the providers of health care who are members of the governing body or executive committee of a health systems agency shall be direct providers of health care (as described in section 1531(3)).

"(iii) The membership shall—

"(I) include (either through consumer or provider members) public elected officials and other representatives of governmental authorities in the agency's health service area and representatives of public and private agencies in the area concerned with health,

"(II) include a percentage of individuals who reside in nonmetropolitan areas within the health service area which percentage is equal to the percentage of residents of the area who reside in nonmetropolitan areas, and

"(III) if the health systems agency serves an area in which there is located one or more hospitals or other health care facilities of the Veterans' Administration, include, as an ex officio member, an individual whom the Chief Medical Director of the Veterans' Administration shall have designated for such purpose, and if the agency serves an area in which there is located one or more qualified health maintenance organizations (within the meaning of section 1310), include at least one member who is representative of such organizations.

42 USC 300e

"(iv) If, in the exercise of its functions, a governing body or executive committee appoints a subcommittee of its members or an advisory group, it shall, to the extent practicable, make its appointments to any such subcommittee or group in such a manner as to provide the representation on such subcommittee or group described in this subparagraph.

"(4) INDIVIDUAL LIABILITY.—No individual who, as a member or employee of a health systems agency, shall, by reason of his performance of any duty, function, or activity required of, or authorized to be undertaken by, the agency under this title, be liable for the payment of damages under any law of the United States or any State (or political subdivision thereof) if he has acted within the scope of such duty, function, or activity, has exercised due care, and has acted, with respect to that performance, without malice toward any person affected by it.

"(5) PRIVATE CONTRIBUTIONS.—No health systems agency may accept any funds or contributions of services or facilities from any individual or private entity which has a financial, fiduciary, or other direct interest in the development, expansion, or support of health resources unless, in the case of an entity, it is an organization described in section 509(a) of the Internal Revenue Code of 1954 and is not directly engaged in the provision of health care in the health service area of the agency. For purposes of this paragraph, an entity shall not be considered to have such an interest solely on the basis of its providing (directly or indirectly) health care for its employees.

26 USC 509.

"(6) OTHER REQUIREMENTS.—Each health system agency shall—

Reports; record-keeping.

"(A) make such reports, in such form and containing such information, concerning its structure, operations, performance of functions, and other matters as the Secretary may from time to time require, and keep such records and afford such access thereto as the Secretary may find necessary to verify such reports;

"(B) provide for such fiscal control and fund accounting procedures as the Secretary may require to assure proper disbursement of, and accounting for, amounts received from the Secretary under this title and section 1640; and

Post, p. 227

"(C) permit the Secretary and the Comptroller General of the United States, or their representatives, to have access for the purpose of audit and examination to any books, documents, papers, and records pertinent to the disposition of amounts received from the Secretary under this title and section 1640.

Establishment

"(c) SUBAREA COUNCILS.—A health systems agency may establish subarea advisory councils representing parts of the agencies' health service area to advise the governing body of the agency on the performance of its functions. The composition of a subarea advisory council shall conform to the requirements of subsection (b)(3)(C).

"FUNCTIONS OF HEALTH SYSTEMS AGENCIES

42 USC 3001-2

"SEC. 1513. (a) For the purpose of—

"(1) improving the health of residents of a health service area,

"(2) increasing the accessibility (including overcoming geographic, architectural, and transportation barriers), acceptability, continuity, and quality of the health services provided them,

"(3) restraining increases in the cost of providing them health services, and

health resources.

systems agency shall have as its primary responsibility the provision of effective health planning for its health service area and the promotion of the development within the area of health services, manpower, and facilities which meet identified needs, reduce documented inefficiencies, and implement the health plans of the agency. To meet its primary responsibility, a health systems agency shall carry out the functions described in subsections (b) through (g) of this section.

"(b) In providing health planning and resources development for its health service area, a health systems agency shall perform the following functions:

"(1) The agency shall assemble and analyze data concerning—

"(A) the status (and its determinants) of the health of the residents of its health service area,

"(B) the status of the health care delivery system in the area and the use of that system by the residents of the area,

"(C) the effect the area's health care delivery system has on the health of the residents of the area,

"(D) the number, type, and location of the area's health resources, including health services, manpower, and facilities,

"(E) the patterns of utilization of the area's health resources, and

"(F) the environmental and occupational exposure factors affecting immediate and long-term health conditions.

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th cooper-
ive system.
USC 242d.

In carrying out this paragraph, the agency shall to the maximum extent practicable use existing data (including data developed under Federal health programs) and coordinate its activities with the cooperative system provided for under section 306(e).

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tablishment.

"(2) The agency shall, after appropriate consideration of the recommended national guidelines for health planning policy issued by the Secretary under section 1501, the priorities set forth in section 1502, and the data developed pursuant to paragraph (1), establish, annually review, and amend as necessary a health systems plan (hereinafter in this title referred to as the 'HSP') which shall be a detailed statement of goals (A) describing a healthful environment and health systems in the area which, when developed, will assure that quality health services will be available and accessible in a manner which assures continuity of care, at reasonable cost, for all residents of the area; (B) which are responsive to the unique needs and resources of the area; and (C) which take into account and is consistent with the national guidelines for health planning policy issued by the Secretary under section 1501 respecting supply, distribution, and organization of health resources and services. Before establishing an HSP, a health systems agency shall conduct a public hearing on the proposed HSP and shall give interested persons an opportunity to submit their views orally and in writing. Not less than thirty days prior to such hearing, the agency shall publish in at least two newspapers of general circulation throughout its health service area a notice of its consideration of the proposed HSP, the time and place of the hearing, the place at which interested persons may consult the HSP in advance of the hearing, and the place and period during which to submit written comments to the agency on the HSP.

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ablishment.

"(3) The agency shall establish, annually review, and amend as necessary an annual implementation plan (hereinafter in this title referred to as the 'AIP') which describes objectives which will achieve the goals of the HSP and priorities among the objectives. In establishing the AIP, the agency shall give priority to those objectives which will maximally improve the health of the residents of the area, as determined on the basis of the relation of the cost of attaining such objectives to their benefits, and which are fitted to the special needs of the area.

"(4) The agency shall develop and publish specific plans and projects for achieving the objectives established in the AIP.

"(c) A health systems agency shall implement its HSP and AIP, and in implementing the plans it shall perform at least the following functions:

"(1) The agency shall seek, to the extent practicable, to implement its HSP and AIP with the assistance of individuals and public and private entities in its health service area.

"(2) The agency may provide, in accordance with the priorities established in the AIP, technical assistance to individuals and public and private entities for the development of projects and programs which the agency determines are necessary to achieve the health systems described in the HSP, including assistance in meeting the requirements of the agency prescribed under section 1532(b).

Grants and contracts.

"(3) The agency shall, in accordance with the priorities established in the AIP, make grants to public and nonprofit private entities and enter into contracts with individuals and public and nonprofit private entities to assist them in planning and developing projects and programs which the agency determines are necessary for the achievement of the health systems described in the HSP. Such grants and contracts shall be made from the Area Health Services Development Fund of the agency established with funds provided under grants made under section 1640. No grants or contract under this subsection may be used (A) to pay the costs incurred by an entity or individual in the delivery of health services (as defined in regulations of the Secretary), or (B) for the cost of construction or modernization of medical facilities. No single grant or contract made or entered into under this paragraph shall be available for obligation beyond the one year period beginning on the date the grant or contract was made or entered into. If an individual or entity receives a grant or contract under this paragraph for a project or program, such individual or entity may receive only one more such grant or contract for such project or program.

Post, p. 227

Limitation.

Coordination.

"(d) Each health systems agency shall coordinate its activities with—

"(1) each Professional Standards Review Organization (designated under section 1152 of the Social Security Act),

42 USC 1320c-

"(2) entities referred to in paragraphs (1) and (2) of section 204(a) of the Demonstration Cities and Metropolitan Development Act of 1966 and regional and local entities the views of which are required to be considered under regulations prescribed under section 403 of the Intergovernmental Cooperation Act of 1968 to carry out section 401(b) of such Act,

42 USC 3334.

42 USC 4233,
4231.

"(3) other appropriate general or special purpose regional planning or administrative agencies, and

"(4) any other appropriate entity,

in the health system agency's health service area. The agency shall, as appropriate, secure data from them for use in the agency's planning and development activities, enter into agreements with them which will assure that actions taken by such entities which alter the area's

health system will be taken in ... to the extent practicable, ... technical assistance to such entities.

Use of Federal funds, approval.

"(e)(1)(A) Except as provided in subparagraph (B), each health systems agency shall review and approve or disapprove each proposed use within its health service area of Federal funds—

42 USC 2681 note.

42 USC 4571.

"(i) appropriated under this Act, the Community Mental Health Centers Act, or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 for grants, contracts, loans, or loan guarantees for the development, expansion, or support of health resources; or

"(ii) made available by the State in which the health service area is located (from an allotment to the State under an Act referred to in clause (i)) for grants or contracts for the development, expansion, or support of health resources.

42 USC 281, 282, 296.

"(B) A health systems agency shall not review and approve or disapprove the proposed use within its health service area of Federal funds appropriated for grants or contracts under title IV, VII, or VIII of this Act unless the grants or contracts are to be made, entered into, or used to support the development of health resources intended for use in the health service area or the delivery of health services. In the case of a proposed use within the health service area of a health systems agency of Federal funds described in subparagraph (A) by an Indian tribe or inter-tribal Indian organization for any program or project which will be located within or will specifically serve—

"(i) a federally-recognized Indian reservation,

"(ii) any land area in Oklahoma which is held in trust by the United States for Indians or which is a restricted Indian-owned land area, or

43 USC 1602.

"(iii) a Native village in Alaska (as defined in section 3(c) of the Alaska Native Claims Settlement Act),

a health systems agency shall only review and comment on such proposed use.

"(2) Notwithstanding any other provision of this Act or any other Act referred to in paragraph (1), the Secretary shall allow a health systems agency sixty days to make the review required by such paragraph. If an agency disapproves a proposed use in its health service area of Federal funds described in paragraph (1), the Secretary may not make such Federal funds available for such use until he has made, upon request of the entity making such proposal, a review of the agency decision. In making any such review of any agency decision, the Secretary shall give the appropriate State health planning and development agency an opportunity to consider the decision of the health systems agency and to submit to the Secretary its comments on the decision. The Secretary, after taking into consideration such State agency's comments (if any), may make such Federal funds available for such use, notwithstanding the disapproval of the health systems agency. Each such decision by the Secretary to make funds available shall be submitted to the appropriate health systems agency and State health planning and development agency and shall contain a detailed statement of the reasons for the decision.

Information to Indian tribes or organizations.

"(3) Each health systems agency shall provide each Indian tribe or inter-tribal Indian organization which is located within the agency's health service area information respecting the availability of the Federal funds described in the first sentence of this subsection.

"(f) To assist State health planning and development agencies in carrying out their functions under paragraphs (4) and (5) of section 1523(a) each health systems agency shall review and make recommendations to the appropriate State health planning and development agency respecting the need for new institutional health services proposed to be offered or developed in the health service area of such health systems agency.

Instituti health se ices, rev

"(g)(1) Except as provided in paragraph (2), each health systems agency shall review on a periodic basis (but at least every five years) all institutional health services offered in the health service area of the agency and shall make recommendations to the State health planning and development agency designated under section 1521 for each State in which the health systems agency's health service area is located respecting the appropriateness in the area of such services.

"(2) A health systems agency shall complete its initial review of existing institutional health services within three years after the date of the agency's designation under section 1515(c).

"(h) Each health systems agency shall annually recommend to the State health planning and development agency designated for each State in which the health systems agency's health service area is located (1) projects for the modernization, construction, and conversion of medical facilities in the agency's health service area which projects will achieve the HSP and AIP of the health systems agency, and (2) priorities among such projects.

"ASSISTANCE TO ENTITIES DESIRING TO BE DESIGNATED AS HEALTH SYSTEMS AGENCIES

Technical a nonfinancia assistance. 42 USC 3001

42 USC 240, 299, 242b.

"SEC. 1514. The Secretary may provide all necessary technical and other nonfinancial assistance (including the preparation of prototype plans of organization and operation) to nonprofit private entities (including entities presently receiving financial assistance under section 314(b) or title IX or as experimental health service delivery systems under section 304) which—

"(1) express a desire to be designated as health systems agencies, and

"(2) the Secretary determines have a potential to meet the requirements of a health systems agency specified in sections 1512 and 1513,

to assist such entities in developing applications to be submitted to the Secretary under section 1515 and otherwise in preparing to meet the requirements of this part for designation as a health systems agency.

"DESIGNATION OF HEALTH SYSTEMS AGENCIES

Agreements. 42 USC 3001-

"SEC. 1515. (a) At the earliest practicable date after the establishment under section 1511 of health service areas (but not later than eighteen months after the date of enactment of this title) the Secretary shall enter into agreements in accordance with this section for the designation of health systems agencies for such areas.

"(b)(1) The Secretary may enter into agreements with entities under which the entities would be designated as the health systems agencies for health service areas on a conditional basis with a view to determining their ability to meet the requirements of section 1512 (b), and their capacity to perform the functions prescribed by section 1513.

"(2) During any period of conditional designation (which may not exceed 24 months), the Secretary may require that the entity conditionally designated meet only such of the requirements of section 1512(b) and perform only such of the functions prescribed by section 1513 as he determines such entity to be capable of meeting and performing. The number and type of such requirements and functions

entity conditionally designated becomes capable of added responsibility so that, by the end of such period, the agency may be considered for designation under subsection (c).

ermination. "(3) Any agreement under which any entity is conditionally designated as a health systems agency may be terminated by such entity upon ninety days notice to the Secretary or by the Secretary upon ninety days notice to such entity.

onditional esignation. "(4) The Secretary may not enter into an agreement with any entity under paragraph (1) for conditional designation as a health systems agency for a health service area until—

"(A) the entity has submitted an application for such designation which contains assurances satisfactory to the Secretary that upon completion of the period of conditional designation the applicant will be organized and operated in the manner described in section 1512(b) and will be qualified to perform the functions prescribed by section 1513;

"(B) a plan for the orderly assumption and implementation of the functions of a health systems agency has been received from the applicant and approved by the Secretary; and

"(C) the Secretary has consulted with the Governor of each State in which such health service area is located and with such other State and local officials as he may deem appropriate, with respect to such designation.

In considering such applications, the Secretary shall give priority to an application which has been recommended for approval by each entity which has developed a plan referred to in section 314(b) for all or part of the health service area with respect to which the application was submitted, and each regional medical program established in such area under title IX. 2 USC 246. 2 USC 299.

"(c)(1) The Secretary shall enter into an agreement with an entity for its designation as a health systems agency if, on the basis of an application under paragraph (2) (and, in the case of an entity conditionally designated, on the basis of its performance during a period of conditional designation under subsection (b) as a health systems agency for a health service area), the Secretary determines that such entity is capable of fulfilling, in a satisfactory manner, the requirements and functions of a health systems agency. Any such agreement under this subsection with an entity may be renewed in accordance with paragraph (3), shall contain such provisions respecting the requirements of sections 1512(b) and 1513 and such conditions designed to carry out the purpose of this title, as the Secretary may prescribe, and shall be for a term of not to exceed twelve months; except that, prior to the expiration of such term, such agreement may be terminated— enewal. ermination onditions.

"(A) by the entity at such time and upon such notice to the Secretary as he may by regulation prescribe, or

"(B) by the Secretary, at such time and upon such notice to the entity as the Secretary may by regulation prescribe, if the Secretary determines that the entity is not complying with or effectively carrying out the provisions of such agreement.

pplication. "(2) The Secretary may not enter into an agreement with any entity under paragraph (1) for designation as a health systems agency for a health service area unless the entity has submitted an application to the Secretary for designation as a health systems agency, and the Governor of each State in which the area is located has been consulted respecting such designation of such entity. Such an application shall contain assurances satisfactory to the Secretary that the applicant meets the requirements of section 1512(b) and is qualified to perform or is performing the functions prescribed by section 1513. In considering such applications, the Secretary shall give priority to an application which has been recommended for approval by (A) each entity which has developed a plan referred to in section 314(b) for all or part of the health service area with respect to which the application was submitted, and (B) each regional medical program established in such area under title IX. riority. 42 USC 24

42 USC 29 Renewal. "(3) An agreement under this subsection for the designation of a health systems agency may be renewed by the Secretary for a period not to exceed twelve months if upon review (as provided in section 1535) of the agency's operation and performance of its functions, he determines that it has fulfilled, in a satisfactory manner, the functions of a health systems agency prescribed by section 1513 and continues to meet the requirements of section 1512(b). Post, p.

"(d) If a designation under subsection (b) or (c) of a health systems agency for a health services area is terminated before the date prescribed for its expiration, the Secretary shall, upon application and in accordance with subsection (b) or (c) (as the Secretary determines appropriate), enter into a designation agreement with another entity to be the health systems agency for such area.

"PLANNING GRANTS

42 USC 30 "Sec. 1516. (a) The Secretary shall make in each fiscal year a grant to each health systems agency with which there is in effect a designation agreement under subsection (b) or (c) of section 1515. A grant under this subsection shall be made on such conditions as the Secretary determines is appropriate, shall be used by a health systems agency for compensation of agency personnel, collection of data, planning, and the performance of the functions of the agency, and shall be available for obligation for a period not to exceed the period for which its designation agreement is entered into or renewed (as the case may be). A health systems agency may use funds under a grant under this subsection to make payments under contracts with other entities to assist the health systems agency in the performance of its functions; but it shall not use funds under such a grant to make payments under a grant or contract with another entity for the development or delivery of health services or resources. Use of fun restrictio

"(b)(1) The amount of any grant under subsection (a) to a health systems agency designated under section 1515(b) shall be determined by the Secretary. The amount of any grant under subsection (a) to any health systems agency designated under section 1515(c) shall be the lesser of—

"(A) the product of $0.50 and the population of the health service area for which the agency is designated, or

"(B) $3,750,000,

unless the agency would receive a greater amount under paragraph (2) or (3).

Obligation non-Federal funds. "(2)(A) If the application of a health systems agency for such a grant contains assurances satisfactory to the Secretary that the agency will expend or obligate in the period in which such grant will be available for obligation non-Federal funds meeting the requirements of subparagraph (B) for the purposes for which such grant may be made, the amount of such grant shall be the sum of—

"(i) the amount determined under paragraph (1), and

"(ii) the lesser of (I) the amount of such non-Federal funds with respect to which the assurances were made, or (II) the product of $0.25 and the population of the health service area for which the agency is designated.

subsection (a) which is computed on the basis of the formula prescribed by subparagraph (A) shall—

"(i) not include any funds contributed to the agency by any individual or private entity which has a financial, fiduciary, or other direct interest in the development, expansion, or support of health resources, and

"(ii) be funds which are not paid to the agency for the performance of particular services by it and which are otherwise contributed to the agency without conditions as to their use other than the condition that the funds shall be used for the purposes for which a grant made under this section may be used.

"(3) The amount of a grant under subsection (a) to a health systems agency designated under section 1515(c) may not be less than $175,000.

propriations.

"(c)(1) For the purpose of making payments pursuant to grants made under subsection (a), there are authorized to be appropriated $60,000,000 for the fiscal year ending June 30, 1975, $90,000,000 for the fiscal year ending June 30, 1976, and $125,000,000 for the fiscal year ending June 30, 1977.

"(2) Notwithstanding subsection (b), if the total of the grants to be made under this section to health systems agencies for any fiscal year exceeds the total of the amounts appropriated under paragraph (1) for that fiscal year, the amount of the grant for that fiscal year to each health systems agency shall be an amount which bears the same ratio to the amount determined for that agency for that fiscal year under subsection (b) as the total of the amounts appropriated under paragraph (1) for that fiscal year bears to the total amount required to make grants to all health systems agencies in accordance with the applicable provision of subsection (b); except that the amount of any grant to a health systems agency for any fiscal year shall not be less than $175,000, unless the amount appropriated for that fiscal year under paragraph (1) is less than the amount required to make such a grant to each health systems agency.

"Part C—State Health Planning and Development

"DESIGNATION OF STATE HEALTH PLANNING AND DEVELOPMENT AGENCIES

signation reements. USC 300m.

"Sec. 1521. (a) For the purpose of the performance within each State of the health planning and development functions prescribed by section 1523, the Secretary shall enter into and renew agreements (described in subsection (b)) for the designation of a State health planning and development agency for each State other than a State for which the Secretary may not under subsection (d) enter into, continue in effect, or renew such an agreement.

"(b)(1) A designation agreement under subsection (a) is an agreement with the Governor of a State for the designation of an agency (selected by the Governor) of the government of that State as the State health planning and development agency (hereinafter in this part referred to as the 'State Agency') to administer the State administrative program prescribed by section 1522 and to carry out the State's health planning and development functions prescribed by section 1523. The Secretary may not enter into such an agreement with the Governor of a State unless—

ditions.

"(A) there has been submitted by the State a State administrative program which has been approved by the Secretary,

"(B) an application has been made to the Secretary for such an agreement and the application contains assurances satisfactory to the Secretary that the agency selected by the Governor for designation as the State Agency has the authority and resources to administer the State administrative program of the State and to carry out the health planning and development functions prescribed by section 1523, and

"(C) in the case of an agreement entered into under paragraph (3), there has been established for the State a Statewide Health Coordinating Council meeting the requirements of section 1524.

Plan.

"(2)(A) The agreement entered into with a Governor of a State under subsection (a) may provide for the designation of a State Agency on a conditional basis with a view to determining the capacity of the designated State Agency to administer the State administrative program of the State and to carry out the health planning and development functions prescribed by section 1523. The Secretary shall require as a condition to the entering into of such an agreement that the Governor submit on behalf of the agency to be designated a plan for the agency's orderly assumption and implementation of such functions.

Period of agreement.

"(B) The period of an agreement described in subparagraph (A) may not exceed twenty-four months. During such period the Secretary may require that the designated State Agency perform only such of the functions of a State Agency prescribed by section 1523 as he determines it is capable of performing. The number and type of such functions shall, during such period, be progressively increased as the designated State Agency becomes capable of added responsibility, so that by the end of such period the designated State Agency may be considered for designation under paragraph (3).

Terminatio

"(C) Any agreement with a Governor of a State entered into under subparagraph (A) may be terminated by the Governor upon ninety days' notice to the Secretary or by the Secretary upon ninety days' notice to the Governor.

State Agen designatio

"(3) If, on the basis of an application for designation as a State Agency (and, in the case of an agency conditionally designated under paragraph (2), on the basis of its performance under an agreement with a Governor of a State entered into under such paragraph), the Secretary determines that the agency is capable of fulfilling, in a satisfactory manner, the responsibilities of a State Agency, he shall enter into an agreement with the Governor of the State designating the agency as the State Agency for the State. No such agreement may be made unless an application therefor is submitted to, and approved by, the Secretary. Any such agreement shall be for a term of not to exceed twelve months, except that, prior to the expiration of such term, such agreement may be terminated—

Application submittal t Secretary.

Terminatio

"(A) by the Governor at such time and upon such notice to the Secretary as he may by regulation prescribe, or

"(B) by the Secretary, at such time and upon such notice to the Governor as the Secretary may by regulation prescribe, if the Secretary determines that the designated State Agency is not complying with or effectively carrying out the provisions of such agreement.

An agreement under this paragraph shall contain such provisions as the Secretary may require to assure that the requirements of this part respecting State Agencies are complied with.

Renewal.

"(4) An agreement entered into under paragraph (3) for the designation of a State Agency may be renewed by the Secretary for a period not to exceed twelve months if he determines that it has fulfilled, in a satisfactory manner, the responsibilities of a State Agency during the period of the agreement to be renewed and if the

Program continues to meet the requirements of section 1522.

"(c) If a designation agreement with the Governor of a State entered into under subsection (b)(2) or (b)(3) is terminated before the date prescribed for its expiration, the Secretary shall, upon application and in accordance with subsection (b)(2), or (b)(3) (as the Secretary determines appropriate), enter into another agreement with the Governor for the designation of a State Agency.

"(d) If, upon the expiration of the fourth fiscal year which begins after the calendar year in which the National Health Policy, Planning, and Resources Development Act of 1974 is enacted, an agreement under this section for the designation of a State Agency for a State is not in effect, the Secretary may not make any allotment, grant, loan, or loan guarantee, or enter into any contract, under this Act, the Community Mental Health Centers Act, or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 for the development, expansion, or support of health resources in such State until such time as such an agreement is in effect.

USC 2681
e.
USC 4571.

"STATE ADMINISTRATIVE PROGRAM

USC 300m-1.

"SEC. 1522. (a) A State administrative program (hereinafter in this section referred to as the 'State Program') is a program for the performance within the State by its State Agency of the functions prescribed by section 1523. The Secretary may not approve a State Program for a State unless it—

nditions.

"(1) meets the requirements of subsection (b);

"(2) has been submitted to the Secretary by the Governor of the State at such time and in such detail, and contains or is accompanied by such information, as the Secretary deems necessary; and

"(3) has been submitted to the Secretary only after the Governor of the State has afforded to the general public of the State a reasonable opportunity for a presentation of views on the State Program.

"(b) The State Program of a State must—

ctions.

"(1) provide for the performance within the State (after the designation of a State Agency and in accordance with the designation agreement) of the functions prescribed by section 1523 and specify the State Agency of the State as the sole agency for the performance of such functions (except as provided in subsection (b) of such section) and for the administration of the State Program;

"(2) contain or be supported by satisfactory evidence that the State Agency has under State law the authority to carry out such functions and the State Program in accordance with this part and contain a current budget for the operation of the State Agency;

"(3) provide for adequate consultation with, and authority for, the Statewide Health Coordinating Council (prescribed by section 1524), in carrying out such functions and the State Program;

"(4)(A) set forth in such detail as the Secretary may prescribe the qualifications for personnel having responsibilities in the performance of such functions and the State Program, and require the State Agency to have a professional staff for planning and a professional staff for development, which staffs shall be of such size and meet such qualifications as the Secretary may prescribe;

"(B) provide for such methods of administration as are found by the Secretary to be necessary for the proper and efficient administration of such functions and the State Program, including methods relating to the establishment and maintenance of personnel standards on a merit basis consistent with such standards as are or may be established by the Civil Service Commission under section 208(a) of the Intergovernmental Personnel Act of 1970 (Public Law 91-648), but the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with the methods relating to personnel standards on a merit basis established and maintained in conformity with this paragraph;

42 USC 4

"(5) require the State Agency to perform its functions in accordance with procedures and criteria established and published by it, which procedures and criteria shall conform to the requirements of section 1532;

"(6) require the State Agency to (A) conduct its business meetings in public, (B) give adequate notice to the public of such meetings, and (C) make its records and data available, upon request, to the public;

"(7)(A) provide for the coordination (in accordance with regulations of the Secretary) with the cooperative system provided for under section 306(e) of the activities of the State Agency for the collection, retrieval, analysis, reporting, and publication of statistical and other information related to health and health care, and (B) require providers of health care doing business in the State to make statistical and other reports of such information to the State Agency;

Coordinat
of inform
tion.
42 USC 24

Reports.

"(8) provide, in accordance with methods and procedures prescribed or approved by the Secretary, for the evaluation, at least annually, of the performance by the State Agency of its functions and of their economic effectiveness;

Performanc
evaluation

"(9) provide that the State Agency will from time to time, and in any event not less often than annually, review the State Program and submit to the Secretary required modifications;

Review of
State
program.

"(10) require the State Agency to make such reports, in such form and containing such information, concerning its structure, operations, performance of functions, and other matters as the Secretary may from time to time require, and keep such records and afford such access thereto as the Secretary may find necessary to verify such reports;

Reports;
recordkeeping.

"(11) require the State Agency to provide for such fiscal control and fund accounting procedures as the Secretary may require to assure proper disbursement of, and accounting for, amounts received from the Secretary under this title;

"(12) permit the Secretary and the Comptroller General of the United States, or their representatives, to have access for the purpose of audit and examination to any books, documents, papers, and records of the State Agency pertinent to the disposition of amounts received from the Secretary under this title; and

Audit.

"(13) provide that if the State Agency makes a decision in the performance of a function under paragraph (3), (4), (5), or (6) of section 1523(a) or under title XVI which is inconsistent with a recommendation made under subsection (f), (g), or (h) of section 1513 by a health systems agency within the State—

"(A) such decision (and the record upon which it was made) shall, upon request of the health systems agency, be reviewed, under an appeals mechanism consistent with State

law governing the [illegible] (other than the State health planning and development agency) designated by the Governor, and

t, p. 2258.

"(B) the decision of the reviewing agency shall for purposes of this title and title XVI be considered the decision of the State health planning and development agency.

te Program, roval and iew.

"(c) The Secretary shall approve any State Program and any modification thereof which complies with subsections (a) and (b). The Secretary shall review for compliance with the requirements of this part the specifications of and operations under each State Program approved by him. Such review shall be conducted not less often than once each year.

"STATE HEALTH PLANNING AND DEVELOPMENT FUNCTIONS

USC 300m-2.

"SEC. 1523. (a) Each State Agency of a State designated under section 1521(b)(3) shall, except as authorized under subsection (b), perform within the State the following functions:

"(1) Conduct the health planning activities of the State and implement those parts of the State health plan (under section 1524(c)(2)) and the plans of the health systems agencies within the State which relate to the government of the State.

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"(2) Prepare and review and revise as necessary (but at least annually) a preliminary State health plan which shall be made up of the HSP's of the health systems agencies within the State. Such preliminary plan may, as found necessary by the State Agency, contain such revisions of such HSP's to achieve their appropriate coordination or to deal more effectively with statewide health needs. Such preliminary plan shall be submitted to the Statewide Health Coordinating Council of the State for approval or disapproval and for use in developing the State health plan referred to in section 1524(c).

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"(3) Assist the Statewide Health Coordinating Council of the State in the review of the State medical facilities plan required under section 1603, and in the performance of its functions generally.

te medical lities , review. , p. 2259.

"(4)(A) Serve as the designated planning agency of the State for the purposes of section 1122 of the Social Security Act if the State has made an agreement pursuant to such section, and (B) administer a State certificate of need program which applies to new institutional health services proposed to be offered or developed within the State and which is satisfactory to the Secretary. Such program shall provide for review and determination of need prior to the time such services, facilities, and organizations are offered or developed or substantial expenditures are undertaken in preparation for such offering or development, and provide that only those services, facilities, and organizations found to be needed shall be offered or developed in the State. In performing its functions under this paragraph the State Agency shall consider recommendations made by health systems agencies under section 1513(f).

USC 1320a-1.

"(5) After consideration of recommendations submitted by health systems agencies under section 1413(f) respecting new institutional health services proposed to be offered within the State, make findings as to the need for such services.

"(6) Review on a periodic basis (but not less often than every five years) all institutional health services being offered in the [illegible] recommendations submitted by health systems agencies under section 1513(g) respecting the appropriateness of such services, make public its findings.

"(b)(1) Any function described in subsection (a) may be performed by another agency of the State government upon request of the Governor under an agreement with the State Agency satisfactory to the Secretary.

"(2) The requirement of paragraph (4)(B) of subsection (a) shall not apply to a State Agency of a State until the expiration of the first regular session of the legislature of such State which begins after the date of enactment of this title.

"(3) A State Agency shall complete its findings with respect to the appropriateness of any existing institutional health service within one year after the date a health systems agency has made its recommendation under section 1513(g) with respect to the appropriateness of the service.

"(c) If a State Agency makes a decision in carrying out a function described in paragraph (4), (5), (6), or (7) of subsection (a) which is not consistent with the goals of the applicable HSP or the priorities of the applicable AIP, the State Agency shall submit to the appropriate health systems agency a detailed statement of the reasons for the inconsistency.

Statement to health systems agency.

"STATEWIDE HEALTH COORDINATING COUNCIL

"SEC. 1524. (a) A State health planning and development agency designated under section 1521 shall be advised by a Statewide Health Coordinating Council (hereinafter in this section referred to as the 'SHCC') which (1) is organized in the manner described by subsection (b), and (2) performs the functions listed in subsection (c).

42 USC 300m-3

"(b)(1) A SHCC of a State shall be composed in the following manner:

Membership.

"(A)(i) A SHCC shall have no fewer than sixteen representatives appointed by the Governor of the State from lists of at least five nominees submitted to the Governor by each of the health systems agencies designated for health service areas which fall, in whole or in part, within the State.

"(ii) Each such health systems agency shall be entitled to the same number of representatives on the SHCC.

"(iii) Each such health systems agency shall be entitled to at least two representatives on the SHCC. Of the representatives of a health systems agency, not less than one-half shall be individuals who are consumers of health care and who are not providers of health care.

"(B) In addition to the appointments made under subparagraph (A), the Governor of the State may appoint such persons (including State officials, public elected officials, and other representatives of governmental authorities within the State) to serve on the SHCC as he deems appropriate; except that (i) the number of persons appointed to the SHCC under this subparagraph may not exceed 40 per centum of the total membership of the SHCC, and (ii) a majority of the persons appointed by the Governor shall be consumers of health care who are not also providers of health care.

"(C) Not less than one-third of the providers of health care who are members of a SHCC shall be direct providers of health care (as described in section 1531(3)).

more hospitals or other health care facilities of the Veterans' Administration are located in a State, the SHCC shall, in addition to the appointed members, include, as an ex officio member, an individual whom the Chief Medical Director of the Veterans' Administration shall have designated as a representative of such facilities.

airman.

"(2) The SHCC shall select from among its members a chairman.

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"(3) The SHCC shall conduct all of its business meetings in public, and shall meet at least once in each calendar quarter of a year.

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port.

"(c) A SHCC shall perform the following functions:

"(1) Review annually and coordinate the HSP and AIP of each health systems agency within the State and report to the Secretary, for purposes of his review under section 1535(c), its comments on such HSP and AIP.

"(2)(A) Prepare and review and revise as necessary (but at least annually) a State health plan which shall be made up of the HSP's of the health systems agencies within the State. Such plan may, as found necessary by the SHCC, contain revisions of such HSP's to achieve their appropriate coordination or to deal more effectively with statewide health needs. Each health systems agency which participates in the SHCC shall make available to the SHCC its HSP for each year for integration into the State health plan and shall, as required by the SHCC, revise its HSP to achieve appropriate coordination with the HSP's of the other agencies which participate in the SHCC or to deal more effectively with statewide health needs.

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"(B) In the preparation and revision of the State health plan, the SHCC shall review and consider the preliminary State health plan submitted by the State agency under section 1523(a)(2), and shall conduct a public hearing on the plan as proposed and shall give interested persons an opportunity to submit their views orally and in writing. Not less than thirty days prior to any such hearing, the SHCC shall publish in at least two newspapers of general circulation in the State a notice of its consideration of the proposed plan, the time and place of the hearing, the place at which interested persons may consult the plan in advance of the hearing, and the place and period during which to direct written comment to the SHCC on the plan.

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"(3) Review annually the budget of each such health systems agency and report to the Secretary, for purposes of his review under section 1535(a), its comments on such budget.

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t, p. 2273.

"(4) Review applications submitted by such health systems agencies for grants under sections 1516 and 1640 and report to the Secretary its comments on such applications.

"(5) Advise the State Agency of the State generally on the performance of its functions.

USC 2681
e.
USC 4571.

"(6) Review annually and approve or disapprove any State plan and any application (and any revision of a State plan or application) submitted to the Secretary as a condition to the receipt of any funds under allotments made to States under this Act, the Community Mental Health Centers Act, or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970. Notwithstanding any other provision of this Act or any other Act referred to in the preceding sentence, the Secretary shall allow a SHCC sixty days to make the review required by such sentence. If a SHCC disapproves such a State plan or application, the Secretary may not make Federal funds available under such State plan or application until he has made, upon request of the Governor of the State which submitted such plan or application or another agency of such State, a review of the SHCC decision. If after such review the Secretary decides to make such funds available, the decision by the Secretary to make such funds available shall be submitted to the SHCC and shall contain a detailed statement of the reasons for the decision.

"GRANTS FOR STATE HEALTH PLANNING AND DEVELOPMENT

42 USC 300

"Sec. 1525. (a) The Secretary shall make grants to State health planning and development agencies designated under subsection (b)(2) or (b)(3) of section 1521 to assist them in meeting the costs of their operation. Any grant made under this subsection to a State Agency shall be available for obligation only for a period not to exceed the period for which its designation agreement is entered into or renewed. The amount of any grant made under this subsection shall be determined by the Secretary, except that no grant to a designated State Agency may exceed 75 per centum of its operation costs (as determined under regulations of the Secretary) during the period for which the grant is available for obligation.

Limitation

"(b) Grants under subsection (a) shall be made on such terms and conditions as the Secretary may prescribe; except that the Secretary may not make a grant to a State Agency unless he receives satisfactory assurances that the State Agency will expend in performing the functions prescribed by section 1523 during the fiscal year for which the grant is sought an amount of funds from non-Federal sources which is at least as great as the average amount of funds expended, in the three years immediately preceding the fiscal year for which such grant is sought, by the State, for which such State Agency has been designated, for the purposes for which funds under such grant may be used (excluding expenditures of a nonrecurring nature).

Appropriati

"(c) For the purpose of making payments under grants under subsection (a), there are authorized to be appropriated $25,000,000 for the fiscal year ending June 30, 1975, $30,000,000 for the fiscal year ending June 30, 1976, and $35,000,000 for the fiscal year ending June 30, 1977.

"GRANTS FOR RATE REGULATION

42 USC 300m

"Sec. 1526. (a) For the purpose of demonstrating the effectiveness of State Agencies regulating rates for the provision of health care, the Secretary may make to a State Agency designated, under an agreement entered into under section 1521(b)(3), for a State which (in accordance with regulations prescribed by the Secretary) has indicated an intent to regulate (not later than six months after the date of the enactment of this title) rates for the provision of health care within the State. Not more than six State Agencies may receive grants under this subsection.

Limitation.

Requirements

"(b)(1) A State Agency which receives a grant under subsection (a) shall—

"(A) provide the Secretary satisfactory evidence that the State Agency has under State law the authority to carry out rate regulation functions in accordance with this section and provide the Secretary a current budget for the performance of such functions by it;

"(B) set forth in such detail as the Secretary may prescribe the qualifications for personnel having responsibility in the performance of such functions, and shall have a professional staff for rate regulation, which staff shall be headed by a Director;

"(C) provide for such methods of administration as found by the Secretary to be necessary for the proper and efficient administration of such functions;

"(D) perform its functions in accordance with procedures established and published by it, which procedures shall conform to the requirements of section 1532;

"(E) comply with the requirements prescribed by paragraphs (6) through (12) of section 1522(b) with respect to the functions prescribed by subsection (a);

"(F) provide for the establishment of a procedure under which the State Agency will obtain the recommendation of the appropriate health systems agency prior to conducting a review of the rates charged or proposed to be charged for services; and

"(G) meet such other requirements as the Secretary may prescribe.

"(2) In prescribing requirements under paragraph (1) of this subsection, the Secretary shall consider the manner in which a State Agency shall perform its functions under a grant under subsection (a), including whether the State Agency should—

"(A) permit those engaged in the delivery of health services to retain savings accruing to them from effective management and cost control,

"(B) create incentives at each point in the delivery of health services for utilization of the most economical modes of services feasible,

"(C) document the need for and cost implications of each new service for which a determination of reimbursement rates is sought, and

"(D) employ for each type or class of person engaged in the delivery of health services—

"(i) a unit for determining the reimbursement rates, and

"(ii) a base for determining rates of change in the reimbursement rates,

which unit and base are satisfactory to the Secretary.

ms and ditions. "(c) Grants under subsection (a) shall be made on such terms and conditions as the Secretary may prescribe, except that (1) such a grant shall be available for obligation only during the one-year period beginning on the date such grant was made, and (2) no State Agency may receive more than three grants under subsection (a).

port to retary. "(d) Each State Agency which receives a grant under subsection (a) shall report to the Secretary (in such form and manner as he shall prescribe) on the effectiveness of the rate regulation program assisted by such grant. The Secretary shall report annually to the Congress on the effectiveness of the programs assisted by the grants authorized by subsection (a).

port to gress.

propria- ns. "(e) There are authorized to be appropriated to make payments under grants under subsection (a), $1,000,000 for the fiscal year ending June 30, 1975, $5,000,000 for the fiscal year ending June 30, 1976, and $6,000,000 for the fiscal year ending June 30, 1977.

"Part D—General Provisions

"definitions

SC 300n. "Sec. 1531. For purposes of this title:

"(1) The term 'State' includes the District of Columbia and the Commonwealth of Puerto Rico.

"(2) The term 'Governor' means the chief executive officer of a State or his designee.

"(3) The term 'provider of health care' means an individual—

"(A) who is a direct provider of health care (including a physician, dentist, nurse, podiatrist, or physician assistant) in that the individual's primary current activity is the provision of health care to individuals or the administration of facilities or institutions (including hospitals, long-term care facilities, outpatient facilities, and health maintenance organizations) in which such care is provided and, when required by State law, the individual has received professional training in the provision of such care or in such administration and is licensed or certified for such provision or administration; or

"(B) who is an indirect provider of health care in that the individual—

"(i) holds a fiduciary position with, or has a fiduciary interest in, any entity described in subclause (II) or (IV) of clause (ii);

"(ii) receives (either directly or through his spouse) more than one-tenth of his gross annual income from any one or combination of the following:

"(I) Fees or other compensation for research into or instruction in the provision of health care.

"(II) Entities engaged in the provision of health care or in such research or instruction.

"(III) Producing or supplying drugs or other articles for individuals or entities for use in the provision of or in research into or instruction in the provision of health care.

"(IV) Entities engaged in producing drugs or such other articles.

"(iii) is a member of the immediate family of an individual described in subparagraph (A) or in clause (i), (ii), or (iv) of subparagraph (B); or

"(iv) is engaged in issuing any policy or contract of individual or group health insurance or hospital or medical service benefits.

"(4) the term 'health resources' includes health services, health professions personnel, and health facilities, except that such term does not include Christian Science sanatoriums operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts.

"(5) The term 'institutional health services' means the health services provided through health care facilities and health maintenance organizations (as such facilities and organizations are defined in regulations prescribed under section 1122 of the Social Security Act) and includes the entities through which such services are provided. 42 USC 1320

"procedures and criteria for reviews of proposed health system changes

"Sec. 1532. (a) In conducting reviews pursuant to subsections (e), (f), and (g) of section 1513 or in conducting any other reviews of proposed or existing health services, each health systems agency shall (except to the extent approved by the Secretary) follow procedures, and apply criteria, developed and published by the agency in accordance with regulations of the Secretary; and in performing its review functions under section 1523, a State Agency shall (except to the extent approved by the Secretary) follow procedures, and apply criteria, developed and published by the State Agency in accordance with regulations of the Secretary. Procedures and criteria for reviews by 42 USC 300n-

and State Agencies may vary according to the purpose for which a particular review is being conducted or the type of health services being reviewed.

Report.

"(b) Each health systems agency and State Agency shall include in the procedures required by subsection (a) at least the following:

"(1) Written notification to affected persons of the beginning of a review.

"(2) Schedules for reviews which provide that no review shall, to the extent practicable, take longer than ninety days from the date the notification described in paragraph (1) is made.

"(3) Provision for persons subject to a review to submit to the agency or State Agency (in such form and manner as the agency or State Agency shall prescribe and publish) such information as the agency or State Agency may require concerning the subject of such review.

"(4) Submission of applications (subject to review by a health systems agency or a State Agency) made under this Act or other provisions of law for Federal financial assistance for health services to the health systems agency or State Agency at such time and in such manner as it may require.

"(5) Submission of periodic reports by providers of health services and other persons subject to agency or State Agency review respecting the development of proposals subject to review.

"(6) Provision for written findings which state the basis for any final decision or recommendation made by the agency or State Agency.

"(7) Notification of providers of health services and other persons subject to agency or State Agency review of the status of the agency or State Agency review of the health services or proposals subject to review, findings made in the course of such review, and other appropriate information respecting such review.

"(8) Provision for public hearings in the course of agency or State Agency review if requested by persons directly affected by the review; and provision for public hearings, for good cause shown, respecting agency and State Agency decisions.

"(9) Preparation and publication of regular reports by the agency and State Agency of the reviews being conducted (including a statement concerning the status of each such review) and of the reviews completed by the agency and State Agency (including a general statement of the findings and decisions made in the course of such reviews) since the publication of the last such report.

"(10) Access by the general public to all applications reviewed by the agency and State Agency and to all other written materials pertinent to any agency or State Agency review.

"(11) In the case of construction projects, submission to the agency and State Agency by the entities proposing the projects of letters of intent in such detail as may be necessary to inform the agency and State Agency of the scope and nature of the projects at the earliest possible opportunity in the course of planning of such construction projects.

"(c) Criteria required by subsection (a) for health systems agency and State Agency review shall include consideration of at least the following:

"(1) The relationship of the health services being reviewed to the applicable HSP and AIP.

"(2) The relationship of services reviewed to the long-range development plan (if any) of the person providing or proposing such services.

"(3) The need that the population served or to be served by such services has for such services.

"(4) The availability of alternatives, less costly, or more effective methods of providing such services.

"(5) The relationship of services reviewed to the existing health care system of the area in which such services are provided or proposed to be provided.

"(6) In the case of health services proposed to be provided, the availability of resources (including health manpower, management personnel, and funds for capital and operating needs) for the provision of such services and the availability of alternative uses of such resources for the provision of other health services.

"(7) The special needs and circumstances of those entities which provide a substantial portion of their services or resources, or both, to individuals not residing in the health service areas in which the entities are located or in adjacent health service areas. Such entities may include medical and other health professions schools, multidisciplinary clinics, specialty centers, and such other entities as the Secretary may by regulation prescribe.

"(8) The special needs and circumstances of health maintenance organizations for which assistance may be provided under title XIII.

42 USC 300

"(9) In the case of a construction project—

"(A) the costs and methods of the proposed construction, and

"(B) the probable impact of the construction project reviewed on the costs of providing health services by the person proposing such construction project.

"TECHNICAL ASSISTANCE FOR HEALTH SYSTEMS AGENCIES AND STATE HEALTH PLANNING AND DEVELOPMENT AGENCIES

42 USC 300

"Sec. 1533. (a) The Secretary shall provide (directly or through grants or contracts, or both) to designated health systems agencies and State Agencies (1) assistance in developing their health plans and approaches to planning various types of health services, (2) technical materials, including methodologies, policies, and standards appropriate for use in health planning, and (3) other technical assistance as may be necessary in order that such agencies may properly perform their functions.

"(b) The Secretary shall include in the materials provided under subsection (a) the following:

"(1)(A) Specification of the minimum data needed to determine the health status of the residents of a health service area and the determinants of such status.

"(B) Specification of the minimum data needed to determine the status of the health resources and services of a health service area.

"(C) Specification of the minimum data needed to describe the use of health resources and services within a health service area.

"(2) Planning approaches, methodologies, policies, and standards which shall be consistent with the guidelines established by the Secretary under section 1501 for appropriate planning and development of health resources, and which shall cover the priorities listed in section 1502.

Ante, p. 2

Guidelines

"(3) Guidelines for the organization and operation of health systems agencies and State Agencies including guidelines for—

"(A) the structure of a health systems agency, consistent with section 1512(b), and of a State Agency, consistent with section 1522;

"(C) the performance of health systems agency functions in accordance with section 1513; and

"(D) the performance of State Agency functions in accordance with section 1523.

nal health ing in- tion ce- lishment.

"(c) In order to facilitate the exchange of information concerning health services, health resources, and health planning and resources development practice and methodology, the Secretary shall establish a national health planning information center to support the health planning and resources development programs of health systems agencies, State Agencies, and other entities concerned with health planning and resources development; to provide access to current information on health planning and resources development; and to provide information for use in the analysis of issues and problems related to health planning and resources development.

"(d) The Secretary shall establish the following within one year of the date of enactment of this title:

tion system.

"(1) A uniform system for calculating the aggregate cost of operation and the aggregate volume of services provided by health services institutions as defined by the Secretary in regulations. Such system shall provide for the calculation of the aggregate volume to be based on:

"(A) The number of patient days;

"(B) The number of patient admissions;

"(C) The number of out-patient visits; and

"(D) Other relevant factors as determined by the Secretary.

ccount- system.

"(2) A uniform system for cost accounting and calculating the volume of services provided by health services institutions. Such system shall:

"(A) Include the establishment of specific cost centers and, where appropriate, subcost centers.

"(B) Include the designation of an appropriate volume factor for each cost center.

"(C) Provide for an appropriate application of such system in the different types of institutions (including hospitals, nursing homes, and other types of health services institutions), and different sizes of such types of institutions.

calcu- system.

"(3) A uniform system for calculating rates to be charged to health insurers and other health institutions payors by health service institutions. Such system shall:

"(A) Be based on an all-inclusive rate for various categories of patients (including, but not limited to individuals receiving medical, surgical, pediatric, obstetric, and psychiatric institutional health services).

"(B) Provide that such rates reflect the true cost of providing services to each such category of patients. The system shall provide that revenues derived from patients in one category shall not be used to support the provision of services to patients in any other category.

"(C) Provide for an appropriate application of such system in the different types of institutions (including hospitals, nursing homes, and other types of health service institutions) and different sizes of such types of institutions.

"(D) Provide that differences in rates to various classes of purchasers (including health insurers, direct service payors, and other health institution payors) be based on justified and documented differences in the costs of operation of health service institutions made possible by the actions of such purchasers.

Classificat system.

"(4) A classification system for health services institutions. Such classification system shall quantitatively describe and group health services institutions of the various types. Factors included in such classification system shall include—

"(A) the number of beds operated by an institution;

"(B) the geographic location of an institution;

"(C) the operation of a postgraduate physician training program by an institution; and

"(D) the complexity of services provided by an institution.

Reporting system.

"(5) A uniform system for the reporting by health services institutions of—

"(A) the aggregate cost of operation and the aggregate volume of services, as calculated in accordance with the system established by the Secretary under paragraph (1);

"(B) the costs and volume of services at various cost centers, and subcost centers, as calculated in accordance with the system established by the Secretary under paragraph (2); and

"(C) rates, by category of patient and class of purchaser, as calculated in accordance with the system established by the Secretary under paragraph (3).

Such system shall provide for an appropriate application of such system in the different types of institutions (including hospitals, nursing homes, and other types of health services institutions) and different sizes of such institutions.

"CENTERS FOR HEALTH PLANNING

42 USC 300n-

"Sec. 1534. (a) For the purposes of assisting the Secretary in carrying out this title, providing such technical and consulting assistance as health systems agencies and State Agencies may from time to time require, conducting research, studies and analyses of health planning and resources development, and developing health planning approaches, methodologies, policies, and standards, the Secretary shall by grants, or contracts, or both, assist public or private nonprofit entities in meeting the costs of planning and developing new centers, and operating existing and new centers, for multidisciplinary health planning development and assistance. To the extent practicable, the Secretary shall provide assistance under this section so that at least five such centers will be in operation by June 30, 1976.

"(b)(1) No grant or contract may be made under this section for planning or developing a center unless the Secretary determines that when it is operational it will meet the requirements listed in paragraph (2) and no grant or contract may be made under this section for operation of a center unless the center meets such requirements.

Requirements

"(2) The requirements referred to in paragraph (1) are as follows:

"(A) There shall be a full-time director of the center who possesses a demonstrated capacity for substantial accomplishment and leadership in the field of health planning and resources development, and there shall be such additional professional staff as may be appropriate.

"(B) The staff of the center shall represent a diversity of relevant disciplines.

“(C) Such additi

“(c) Centers assisted under this section (1) may enter into arrangements with health systems agencies and State Agencies for the provision of such services as may be appropriate and necessary in assisting the agencies and State Agencies in performing their functions under section 1513 or 1523, respectively, and (2) shall use methods (satisfactory to the Secretary) to disseminate to such agencies and State Agencies such planning approaches, methodoligies, policies and standards as they develop.

pria-

“(d) For the purpose of making payments pursuant to grants and contracts under subsection (a) there are authorized to be appropriated $5,000,000 for the fiscal year ending June 30, 1975, $8,000,000 for the fiscal year ending June 30, 1976, and $10,000,000 for the fiscal year ending June 30, 1977.

“REVIEW BY THE SECRETARY

“Sec. 1535. (a) The Secretary shall review and approve or disapprove the annual budget of each designated health systems agency and State Agency. In making such review and approval or disapproval the Secretary shall consider the comments of Statewide Health Coordinating Councils submitted under section 1524(c)(3). Information submitted to the Secretary by a health systems agency or a State Agency in connection with the Secretary's review under this subsection shall be made available by the Secretary, upon request, to the appropriate committees (and their subcommittees) of the Congress.

“(b) The Secretary shall prescribe performance standards covering the structure, operation, and performance of the functions of each designated health systems agency and State Agency, and he shall establish a reporting system based on the performance standards that allows for continuous review of the structure, operation, and performance of the functions of such agencies.

“(c) The Secretary shall review in detail at least every three years the structure, operation, and performance of the functions of each designated health systems agency to determine—

“(1) the adequacy of the HSP of the agency for meeting the needs of the residents of the area for a healthful environment and for accessible, acceptable and continuous quality health care at reasonable costs, and the effectiveness of the AIP in achieving the system described in the HSP;

p. 2232.

“(2) if the structure, operation, and performance of the functions of the agency meet the requirements of sections 1512(b) and 1513;

“(3) the extent to which the agency's governing body (and executive committee (if any)) represents the residents of the health service area for which the agency is designated;

“(4) the professional credentials and competence of the staff of the agency;

“(5) the appropriateness of the data assembled pursuant to section 1513(b)(1) and the quality of the analyses of such data;

“(6) the extent to which technical and financial assistance from the agency have been utilized in an effective manner to achieve goals and objectives of the HSP and the AIP; and

“(7) the extent to which it may be demonstrated that—

“(A) the health of the residents in the agency's health service area has been improved;

“(B) the accessibility, acceptability, continuity, and quality of health care in such area has been improved; and

“(C) increases in costs of the provision of health care have been restrained.

“(d) The Secretary shall review in detail at least every three years the structure, operation, and performance of the functions of each designated State Agency to determine—

“(1) the adequacy of the State health plan of the Statewide Health Coordinating Council prepared under section 1524(c)(2) in meeting the needs of the residents of the State for a healthful environment and for accessible, acceptable, and continuous quality health care at reasonable costs;

“(2) if the structure, operation, and performance of the functions of the State Agency meet the requirements of sections 1522 and 1523;

“(3) the extent to which the Statewide Health Coordinating Council has a membership meeting, and has performed in a manner consistent with, the requirements of section 1524;

“(4) the professional credentials and competence of the staff of the State Agency;

“(5) the extent to which financial assistance provided under title XVI by the State Agency has been used in an effective manner to achieve the State's health plan under section 1524(c)(2); and

“(6) the extent to which it may be demonstrated that—

“(A) the health of the residents of the State has been improved;

“(B) the accessibility, acceptability, continuity, and quality of health care in the State has been improved; and

“(C) increases in costs of the provision of health care have been restrained.

“SPECIAL PROVISIONS FOR CERTAIN STATES AND TERRITORIES

42 USC 300r

“Sec. 1536. (a) Any State which—

“(1) has no county or municipal public health institution or department, and

“(2) has, prior to the date of enactment of this title, maintained a health planning system which substantially complies with the purposes of this title,

and the Virgin Islands, Guam, the Trust Territories in the Pacific Islands, and American Samoa shall each be considered in accordance with subsection (b) to be a State for purposes of this title.

“(b) In the case of an entity which under subsection (a) is to be considered a State for purposes of this title—

“(1) no health service area shall be established within it,

“(2) no health systems agency shall be designated for it,

“(3) the State Agency designated for it under section 1521 may, in addition to the functions prescribed by section 1523, perform the functions prescribed by section 1513 and shall be eligible to receive grants authorized by sections 1516 and 1640, and

“(4) the chief executive office shall appoint the Statewide Health Coordinating Council prescribed by section 1524 in accordance with the regulation of the Secretary.”

REVISION OF HEALTH RESOURCES DEVELOPMENT PROGRAMS UNDER THE PUBLIC HEALTH SERVICE ACT

Sec. 4. The Public Health Service Act, as amended by section 3, is amended by adding after title XV the following new title:

Ante, p. 222

“Part A—Purpose, State Plan, and Project Approval

“PURPOSE

SC 300o.
, p. 2262.
, p. 2264.

“Sec. 1601. It is the purpose of this title to provide assistance, through allotments under part B and loans and loan guarantees and interest subsidies under part C, for projects for—

“(1) modernization of medical facilities;

“(2) construction of new outpatient medical facilities;

“(3) construction of new inpatient medical facilities in areas which have experienced (as determined under regulations of the Secretary) recent rapid population growth; and

“(4) conversion of existing medical facilities for the provision of new health services,

and to provide assistance, through grants under part D, for construction and modernization projects designed to prevent or eliminate safety hazards in medical facilities or to avoid noncompliance by such facilities with licensure or accreditation standards.

“GENERAL REGULATIONS

SC 300o-1.

“Sec. 1602. The Secretary shall by regulation—

“(1) prescribe the general manner in which the State Agency of each State shall determine for the State medical facilities plan under section 1603 the priority among projects within the State for which assistance is available under this title, based on the relative need of different areas within the State for such projects and giving special consideration—

“(A) to projects for medical facilities serving areas with relatively small financial resources and for medical facilities serving rural communities,

“(B) in the case of projects for modernization of medical facilities, to projects for facilities serving densely populated areas,

“(C) in the case of projects for construction of outpatient medical facilities, to projects that will be located in, and provide services for residents of, areas determined by the Secretary to be rural or urban poverty areas,

“(D) to projects designed to (i) eliminate or prevent imminent safety hazards as defined by Federal, State, or local fire, building, or life safety codes or regulations, or (ii) avoid noncompliance with State or voluntary licensure or accreditation standards, and

“(E) to projects for medical facilities which, alone or in conjunction with other facilities, will provide comprehensive health care, including outpatient and preventive care as well as hospitalization;

“(2) prescribe for medical facilities projects assisted under this title general standards of construction, modernization, and equipment for medical facilities of different classes and in different types of location;

“(3) prescribe criteria for determining needs for medical facility beds and needs for medical facilities, and for developing plans for the distribution of such beds and facilities;

“(4) prescribe criteria for determining the extent to which existing medical facilities are in need of modernization;

“(5) require each State medical facilities plan under section 1603 to provide for adequate medical facilities for all persons residing in the State and adequate facilities to furnish needed health services for persons unable to pay therefor; and

“(6) prescribe the general manner in which each entity which receives financial assistance under this title or has received financial assistance under this title or title VI shall be required to comply with the assurances required to be made at the time such assistance was received and the means by which such entity shall be required to demonstrate compliance with such assurances. 42 USC 291.

An entity subject to the requirements prescribed pursuant to paragraph (6) respecting compliance with assurances made in connection with receipt of financial assistance shall submit periodically to the Secretary data and information which reasonably supports the entity's compliance with such assurances. The Secretary may not waive the requirement of the preceding sentence.

“STATE MEDICAL FACILITIES PLAN

42 USC 300o-
Post, p. 226

“Sec. 1603. (a) Before an application for assistance under this title (other than part D) for a medical facility project described in section 1601 may be approved, the State Agency of the State in which such project is located must have submitted to the Secretary and had approved by him a State medical facilities plan. To be approved by the Secretary a State medical facilities plan for a State must—

“(1) prescribe that the State Agency of the State shall administer or supervise the administration of the plan and contain evidence satisfactory to the Secretary that the State Agency has the authority to carry out the plan in conformity with this title;

“(2) prescribe that the Statewide Health Coordinating Council of the State shall advise and consult with the State Agency in carrying out the plan;

“(3) be approved by the Statewide Health Coordinating Council as consistent with the State health plan developed pursuant to section 1524(c)(2);

“(4) set forth, in accordance with criteria established in regulations prescribed under section 1602(a) and on the basis of a statewide inventory of existing medical facilities, a survey of need, and the plans of health systems agencies within the State—

“(A) the number and type of medical facility beds and medical facilities needed to provide adequate inpatient care to people residing in the State, and a plan for the distribution of such beds and facilities in health services areas throughout the State,

“(B) the number and type of outpatient and other medical facilities needed to provide adequate public health services and outpatient care to people residing in the State, and a plan for the distribution of such facilities in health service areas throughout the State, and

“(C) the extent to which existing medical facilities in the State are in need of modernization or conversion to new uses;

“(5) set forth a program for the State for assistance under this title for projects described in section 1601, which program shall indicate the type of assistance which should be made available to each project and shall conform to the assessment of need set forth pursuant to paragraph (4) and regulations promulgated under section 1602(a);

[illegible] promulgated [illegible] (a)) priorities for the provision of assistance under this title for projects in the program set forth pursuant to paragraph (4);

"(7) provide minimum requirements (to be fixed in the discretion of the State Agency) for the maintenance and operation of facilities which receive assistance under this title, and provide for enforcement of such standards;

"(8) provide for affording to every applicant for assistance for a medical facilities project under this title an opportunity for a hearing before the State Agency; and

"(9) provide that the State Agency will from time to time, but not less often than annually, review the plan and submit to the Secretary any modifications thereof which it considers necessary.

"(b) The Secretary shall approve any State medical facilities plan and any modification thereof which complies with the provisions of subsection (a) if the State Agency, as determined under the review made under section 1535(d), is organized and operated in the manner prescribed by section 1522 and is carrying out its functions under section 1523 in a manner satisfactory to the Secretary. If any such plan or modification thereof shall have been disapproved by the Secretary for failure to comply with subsection (a), the Secretary shall, upon request of the State Agency, afford it an opportunity for hearing.

"APPROVAL OF PROJECTS

USC 300o-3.

"SEC. 1604. (a) For each project described in section 1601 and included within a State's State medical facilities plan approved under section 1603 there shall be submitted to the Secretary, through the State's State Agency, an application. An application for a grant under section 1625 shall be submitted directly to the Secretary. Except as provided in section 1625, the applicant under such an application may be a State, a political subdivision of a State or any other public entity, or a private nonprofit entity. If two or more entities join in a project, an application for such project may be filed by any of such entities or by all of them.

lication uirements.

"(b)(1) Except as authorized under paragraph (2), an application for any project shall set forth—

"(A) in the case of a modernization project for a medical facility for continuation of existing health services, a finding by the State Agency of a continued need for such services, and, in the case of any other project for a medical facility, a finding by the State Agency of the need for the new health services to be provided through the medical facility upon completion of the project;

"(B) a description of the site of such project;

"(C) plans and specifications therefor which meet the requirements of the regulations prescribed under section 1602(a);

"(D) reasonable assurance that title to such site is or will be vested in one or more of the entities filing the application or in a public or other nonprofit entity which is to operate the facility on completion of the project;

"(E) reasonable assurance that adequate financial support will be available for the completion of the project and for its maintenance and operation when completed, and, for the purpose of determining if the requirements of this subparagraph are met, Federal assistance provided directly to a medical facility which is located in an area determined by the Secretary to be an urban or rural poverty area or through benefits provided individuals served at such facility shall be considered as financial support;

"(F) the type of assistance being sought under this title for the project;

"(G) except in the case of a project under section 1625, a certification by the State Agency of the Federal share for the project;

"(H) reasonable assurance that all laborers and mechanics employed by contractors or subcontractors in the performance of work on a project will be paid wages at rates not less than those prevailing on similar construction in the locality as determined by the Secretary of Labor in accordance with the Act of March 3, 1931 (40 U.S.C. 276a—276a-5, known as the Davis-Bacon Act), and the Secretary of Labor shall have with respect to such labor standards the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (15 F.R. 3176; 5 U.S.C. Appendix) and section 2 of the Act of June 13, 1934 (40 U.S.C. 276c);

40 USC 27 note.

"(I) in the cast of a project for the construction or modernization of an outpatient facility, reasonable assurance that the services of a general hospital will be available to patients at such facility who are in need of hospital care; and

"(J) reasonable assurance that at all times after such application is approved (i) the facility or portion thereof to be constructed, or modernized, or converted will be made available to all persons residing or employed in the area served by the facility, and (ii) there will be made available in the facility or portion thereof to be constructed, modernized, or converted a reasonable volume of services to persons unable to pay therefor and the Secretary, in determining the reasonableness of the volume of services provided, shall take into consideration the extent to which compliance is feasible from a financial viewpoint.

Waiver.

"(2)(A) The Secretary may waive—

"(i) the requirements of subparagraph (C) of paragraph (1) for compliance with modernization and equipment standards prescribed pursuant to section 1602(a)(2), and

"(ii) the requirement of subparagraph (D) of paragraph (1) respecting title to a project site,

in the case of an application for a project described in subparagraph (B).

"(B) A project referred to in subparagraph (A) is a project—

"(i) for the modernization of an outpatient medical facility which will provide general purpose health services, which is not part of a hospital, and which will serve a medically underserved population as defined in section 1633 or as designated by a health systems agency, and

"(ii) for which the applicant seeks (I) not more than $20,000 from the allotments made under part B to the State in which it is located, or (II) a loan under part C the principal amount of which does not exceed $20,000.

Post, p.
Post, p.

"(c) The Secretary shall approve an application submitted under subsection (b) (other than an application for a grant under section 1625) if—

"(1) in the case of a project to be assisted from an allotment made under part B, there are sufficient funds in such allotment to pay the Federal share of the project; and

"(2) the Secretary finds that—

"(A) the application (i) is in conformity with the State medical facilities plan approved under section 1603, (ii) has been approved and recommended by the State Agency, (iii) is for a project which is entitled to priority over other projects within the State as determined in accordance with the

(iv) contains
required by subsection (b); and

"(B) the plans and specifications for the project meet the requirements of the regulations prescribed pursuant to section 1602(a).

"(d) No application (other than an application for a grant under section 1625) shall be disapproved until the Secretary has afforded the State Agency an opportunity for a hearing.

"(e) Amendment of any approved application shall be subject to approval in the same manner as an original application.

e, p. 2235. "(f) Each application shall be reviewed by health systems agencies in accordance with section 1513(e).

"Part B—Allotments

"Allotments

USC 300p. "Sec. 1610. (a) For each fiscal year, the Secretary shall, in accordance with regulations, make from sums appropriated for such fiscal year under section 1613 allotments among the States on the basis of the population, the financial need, and need for medical facilities projects described in section 1604 of the respective States. The population of the States shall be determined on the basis of the latest figures certified by the Secretary of Commerce.

itation. "(b)(1) The allotment to any State (other than Guam, American Samoa, the Virgin Islands, or the Trust Territory of the Pacific Islands) for any fiscal year shall be not less than $1,000,000; and the allotment to Guam, American Samoa, the Virgin Islands, and the Trust Territory of the Pacific Islands for any fiscal year shall be not less than $500,000 each.

"(2) Notwithstanding paragraph (1), if the amount appropriated under section 1613 for any fiscal year is less than the amount required to provide allotments in accordance with paragraph (1), the amount of the allotment to any State for such fiscal year shall be an amount which bears the same ratio to the amount prescribed for such State by paragraph (1) as the amount appropriated for such fiscal year bears to the amount of appropriations needed to make allotments to all the States in accordance with paragraph (1).

"(c) Any amount allotted to a State for a fiscal year under subsection (a) and remaining unobligated at the end of such year shall remain available to such State, for the purpose for which made, for the next two fiscal years (and for such years only), in addition to the amounts allotted to such State for such purposes for such next two fiscal years; except that any such amount which is unobligated at the end of the first of such next two years and which the Secretary determines will remain unobligated at the close of the second of such next two years may be reallotted by the Secretary, to be available for the purposes for which made until the close of the second of such next two years, to other States which have need therefor, on such basis as the Secretary deems equitable and consistent with the purposes of this title. Any amount so reallotted to a State shall be in addition to the amounts allotted and available to the State for the same period.

"Payments from Allotments

USC 300p-1. "Sec. 1611. (a) If with respect to any medical facility project approved under section 1604 the State Agency certifies (a) on the basis of inspection by it) to the Secretary that, in accordance with approved plans and specifications, work has been performed upon the project or purchases have been made for it and that payment from the applicable allotment of the State in which the project is located is due for the project, the Secretary shall, except as provided in subsection (b), make such payment to the State.

"(b) The Secretary is authorized to not make payments to a State pursuant to subsection (a) in the following circumstances: Payment restrict

"(1) If such State is not authorized by law to make payments for an approved medical facility project from the payment to be made by the Secretary pursuant to subsection (a), or if the State so requests, the Secretary shall make the payment from the State allotment directly to the applicant for such project.

"(2) If the Secretary, after investigation or otherwise, has reason to believe that any act (or failure to act) has occurred requiring action pursuant to section 1612, payment by the Secretary may, after he has given the State Agency notice and opportunity for hearing pursuant to such section, be withheld, in whole or in part, pending corrective action or action based on such hearing.

In no event may the total of payments made under subsection (a) with respect to any project exceed an amount equal to the Federal share of such project.

"(c) In case an amendment to an approved application is approved as provided in section 1604 or the estimated cost of a project is revised upward, any additional payment with respect thereto may be made from the applicable allotment of the State for the fiscal year in which such amendment or revision is approved.

"(d) In any fiscal year—

"(1) not more than 20 per centum of the amount of a State's allotment available for obligation in that fiscal year may be obligated for projects in the State for construction of new facilities for the provision of inpatient health care to persons residing in areas of the State which have experienced recent rapid population growth; and

"(2) not less than 25 per centum of the amount of a State's allotment available for obligation in that fiscal year shall be obligated for projects for outpatient facilities which will serve medically underserved populations.

In the administration of this part, the Secretary shall seek to assure that in each fiscal year at least one half of the amount obligated for projects pursuant to paragraph (2) shall be obligated for projects which will serve rural medically underserved populations. Rural projects.

"Withholding of Payments and Other Compliance Actions

"Sec. 1612. (a) Whenever the Secretary, after reasonable notice and opportunity for hearing to the State Agency concerned finds— 42 USC 30

"(1) that the State Agency is not complying substantially with the provisions required by section 1603 to be included in its State medical facilities plan,

"(2) that any assurance required to be given in an application filed under section 1604 is not being or cannot be carried out, or

"(3) that there is a substantial failure to carry out plans and specifications approved by the Secretary under section 1604,

the Secretary shall take the action authorized by subsection (b) unless, in the case of compliance with assurances, the Secretary requires compliance by other means authorized by law.

"(b)(1) Upon a finding described in subsection (a) and after notice to the State Agency concerned, the Secretary may—

the State with respect to which the finding was made further payments from the State's allotment under section 1610, or

"(B) withhold from the specific projects with respect to which the finding was made further payments from the applicable State allotment under section 1610.

"(2) Payments may be withheld, in whole or in part, under paragraph (1)—

"(A) until the basis for the finding upon which the withholding was made no longer exists, or

"(B) if corrective action to make such finding inapplicable cannot be made, until the State concerned repays or arranges for the repayment of Federal funds paid under this part for projects which because of the finding are not entitled to such funds.

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USC 291.

"(c) The Secretary shall investigate and ascertain, on a periodic basis, with respect to each entity which is receiving financial assistance under this title or which has received financial assistance under title VI or this title, the extent of compliance by such entity with the assurances required to be made at the time such assistance was received. If the Secretary finds that such an entity has failed to comply with any such assurance, the Secretary shall take the action authorized by subsection (b) or take any other action authorized by law (including an action for specific performance brought by the Attorney General upon request of the Secretary) which will effect compliance by the entity with such assurances. An appropriate action to effectuate compliance with any such assurance may be brought by a person other than the Secretary only if a complaint has been filed by such person with the Secretary and the Secretary has dismissed such complaint or the Attorney General has not brought a civil action for compliance with such assurance within 6 months after the date on which the complaint was filed with the Secretary.

"AUTHORIZATION OF APPROPRIATIONS

USC 300p-3.

"SEC. 1613. Except as provided in section 1625(d), there are authorized to be appropriated for allotments under section 1510 $125,000,000 for the fiscal year ending June 30, 1975, $130,000,000 for the fiscal year ending June 30, 1976, and $135,000,000 for the fiscal year ending June 30, 1977.

"PART C—LOANS AND LOAN GUARANTEES

"AUTHORITY FOR LOANS AND LOAN GUARANTEES

USC 300q.

"SEC. 1620. (a) The Secretary, during the period beginning July 1, 1974, and ending June 30, 1977, may, in accordance with this part, make loans from the fund established under section 1622(d) to pay the Federal share of projects approved under section 1604.

"(b)(1) The Secretary, during the period beginning July 1, 1974, and ending June 30, 1977, may, in accordance with this part, guarantee to—

"(i) non-Federal lenders for their loans to nonprofit private entities for medical facilities projects, and

"(ii) the Federal Financing Bank for its loans to nonprofit private entities for such projects,

payment of principal and interest on such loans if applications for assistance for such projects under this title have been approved under section 1604.

"(2) In the case of a guarantee of any loan to a nonprofit private entity under this title, the Secretary shall pay, to the holder of such loan and for and on behalf of the project for which the loan was made amounts sufficient to reduce by 3 per centum per annum the net effective interest rate otherwise payable on such loan. Each holder of such a loan which is guaranteed under this title shall have a contractual right to receive from the United States interest payments required by the preceding sentence.

Interest payments.

"(c) The cumulative total of the principal of the loans outstanding at any time with respect to which guarantees have been issued, or which have been directly made, may not exceed such limitations as may be specified in appropriation Acts.

Limitation

"(d) The Secretary, with the consent of the Secretary of Housing and Urban Development, shall obtain from the Department of Housing and Urban Development such assistance with respect to the administration of this part as will promote efficiency and economy thereof.

HUD assistance.

"ALLOCATION AMONG THE STATES

"SEC. 1621. (a) For each fiscal year, the total amount of principal of—

42 USC 300

"(1) loans to nonprofit private entities which may be guaranteed, or

"(2) loans which may be directly made,

under this part shall be allotted by the Secretary among the States, in accordance with regulations, on the basis of the population, financial need, and need for medical facilities projects described in section 1601 of the respective States. The population of the States shall be determined on the basis of the latest figures certified by the Secretary of Commerce.

"(b) Any amount allotted to a State for a fiscal year under subsection (a) and remaining unobligated at the end of such year shall remain available to such State, for the purpose for which made, for the next two fiscal years (and for such years only), in addition to the amounts allotted to such State for such purposes for such next two fiscal years; except that any such amount which is unobligated at the end of the first of such next two years and which the Secretary determines will remain unobligated at the close of the second of such next two years may be reallotted by the Secretary, to be available for the purposes for which made until the close of the second of such next two years, to other States which have need therefor, on such basis as the Secretary deems equitable and consistent with the purposes of this title. Any amount so reallotted to a State shall be in addition to the amounts allotted and available to the State for the same period.

Unobligated funds, availability to State.

Reallotment

"GENERAL PROVISIONS RELATING TO LOAN GUARANTEES AND LOANS

"SEC. 1622. (a)(1) The Secretary may not approve a loan guarantee for a project under this part unless he determines that (A) the terms, conditions, security (if any), and schedule and amount of repayments with respect to the loan are sufficient to protect the financial interests of the United States and are otherwise reasonable, including a determination that the rate of interest does not exceed such per centum per annum on the principal obligation outstanding as the Secretary determines to be reasonable, taking into account the range of interest rates prevailing in the private market for similar loans and the risks assumed by the United States, and (B) the loan would

42 USC 300

not be available on reasonable terms and [illegible]

[illegible] States shall be entitled to recover from the applicant for a loan guarantee under this part the amount of any payment made pursuant to such guarantee, unless the Secretary for good cause waives such right of recovery; and, upon making any such payment, the United States shall be subrogated to all of the rights of the recipient of the payments with respect to which the guarantee was made.

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"(B) To the extent permitted by subparagraph (C), any terms and conditions applicable to a loan guarantee under this part (including terms and conditions imposed under subparagraph (D)) may be modified by the Secretary to the extent he determines it to be consistent with the financial interest of the United States.

"(C) Any loan guarantee made by the Secretary under this part shall be incontestable (i) in the hands of an applicant on whose behalf such guarantee is made unless the applicant engaged in fraud or misrepresentation in securing such guarantee, and (ii) as to any person (or his successor in interest) who makes or contracts to make a loan to such applicant in reliance thereon unless such person (or his successor in interest) engaged in fraud or misrepresentation in making or contracting to make such loan.

"(D) Guarantees of loans under this part shall be subject to such further terms and conditions as the Secretary determines to be necessary to assure that the purposes of this title will be achieved.

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ditions.

"(b)(1) The Secretary may not approve a loan under this part unless—

"(A) the Secretary is reasonably satisfied that the applicant under the project for which the loan would be made will be able to make payments of principal and interest thereon when due, and

"(B) the applicant provides the Secretary with reasonable assurances that there will be available to it such additional funds as may be necessary to complete the project or undertaking with respect to which such loan is requested.

"(2) Any loan made under this part shall (A) have such security, (B) have such maturity date, (C) be repayable in such installments, (D) bear interest at a rate comparable to the current rate of interest prevailing, on the date the loan is made, with respect to loans guaranteed under this part, minus 3 per centum per annum, and (E) be subject to such other terms and conditions (including provisions for recovery in case of default), as the Secretary determines to be necessary to carry out the purposes of this title while adequately protecting the financial interests of the United States.

"(3) The Secretary may, for good cause but with due regard to the financial interests of the United States, waive any right of recovery which he has by reasons of the failure of a borrower to make payments of principal of and interest on a loan made under this part, except that if such loan is sold and guaranteed, any such waiver shall have no effect upon the Secretary's guarantee of timely payment of principal and interest.

"(c)(1) The Secretary shall from time to time, but with due regard to the financial interests of the United States, sell loans made under this part either on the private market or to the Federal National Mortgage Association in accordance with section 302 of the Federal National Mortgage Association Charter Act or to the Federal Financing Bank.

"(2) Any loan so sold shall be sold for an amount which is equal (or approximately equal) to the amount of the unpaid principal of such loans as of time of sale.

"(3)(A) The Secretary is authorized to enter into an agreement with the purchaser of any loan sold under this part under which the Secretary agrees—

"(i) to guarantee to such purchaser (and any successor in interest to such purchaser) payments of the principal and interest payable under such loan, and

"(ii) to pay as an interest subsidy to such purchaser (and any successor in interest of such purchaser) amounts which, when added to the amount of interest payable on such loan, are equivalent to a reasonable rate of interest on such loan as determined by the Secretary after taking into account the range of prevailing interest rates in the private market on similar loans and the risks assumed by the United States.

"(B) Any agreement under subparagraph (A)—

"(i) may provide that the Secretary shall act as agent of any such purchaser, for the purpose of collecting from the entity to which such loan was made and paying over to such purchaser any payments of principal and interest payable by such entity under such loan;

"(ii) may provide for the repurchase by the Secretary of any such loan on such terms and conditions as may be specified in the agreement;

"(iii) shall provide that, in the event of any default by the entity to which such loan was made in payment of principal or interest due on such loan, the Secretary shall, upon notification to the purchaser (or to the successor in interest of such purchaser), have the option to close out such loan (and any obligations of the Secretary with respect thereto) by paying to the purchaser (or his successor in interest) the total amount of outstanding principal and interest due thereon at the time of such notification; and

"(iv) shall provide that, in the event such loan is closed out as provided in clause (iii), or in the event of any other loss incurred by the Secretary by reason of the failure of such entity to make payments of principal or interest on such loan, the Secretary shall be subrogated to all rights of such purchaser for recovery of such loss from such entity.

"(4) Amounts received by the Secretary as proceeds from the sale of loans under this subsection shall be deposited in the fund established under subsection (d).

Loan ar
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"(d)(1) There is established in the Treasury a loan and loan guarantee fund (hereinafter in this subsection referred to as the 'fund') which shall be available to the Secretary without fiscal year limitation, in such amounts as may be specified from time to time in appropriation Acts—

"(A) to enable him to make loans under this part,

"(B) to enable him to discharge his responsibilities under loan guarantees issued by him under this part,

"(C) for payment of interest under section 1620(b)(2) on loans guaranteed under this part,

"(D) for repurchase of loans under subsection (c)(3)(B), and

"(E) for payment of interest on loans which are sold and guaranteed.

Appropri

There are authorized to be appropriated from time to time such amounts as may be necessary to provide the sums required for the fund. There shall also be deposited in the fund amounts received by the Secretary in connection with loans and loan guarantees under this part and other property or assets derived by him from his operations

respecting [illegible] assets. [illegible] including any money

(2) If at any time the sums in the funds are insufficient to enable the Secretary—

"(A) to make payments of interest under section 1620(b)(2),

"(B) to otherwise comply with guarantees under this part of loans to nonprofit private entities,

"(C) in the case of a loan which was made, sold, and guaranteed under this part, to make to the purchaser of such loan payments of principal and interest on such loan after default by the entity to which the loan was made, or

"(D) to repurchase loans under subsection (c)(3)(B), and

"(E) to make payments of interest on loans which are sold and guaranteed,

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he is authorized to issue to the Secretary of the Treasury notes or other obligations in such forms and denominations, bearing such maturities, and subject to such terms and conditions, as may be prescribed by the Secretary with the approval of the Secretary of the Treasury. Such notes or other obligations shall bear interest at a rate determined by the Secretary of the Treasury, taking into consideration the current average market yield on outstanding marketable obligations of the United States of comparable maturities during the month preceding the issuance of the notes or other obligations. The Secretary of the Treasury shall purchase any notes and other obligations issued under this paragraph and for that purpose he may use as a public debt transaction the proceeds from the sale of any securities issued under the Second Liberty Bond Act, and the purposes for which the securities may be issued under that Act are extended to include any purchase of such notes and obligations. The Secretary of the Treasury may at any time sell any of the notes or other obligations acquired by him under this paragraph. All redemptions, purchases, and sales by the Secretary of the Treasury of such notes or other obligations shall be treated as a public debt transactions of the United States. Sums borrowed under this paragraph shall be deposited in the fund and redemption of such notes and obligations shall be made by the Secretary from the fund.

USC 774.

"(e)(1) The assets, commitments, obligations, and outstanding balances of the loan guarantee and loan fund established in the Treasury by section 626 shall be transferred to the fund established by subsection (d) of this section.

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USC 291j-6.

"(2) To provide additional capitalization for the fund established under subsection (d) there are authorized to be appropriated to the fund, such sums as may be necessary for the fiscal years ending June 30, 1975, June 30, 1976, and June 30, 1977.

ropriation.

"Part D—Project Grants

"PROJECT GRANTS

SC 300r.

"Sec. 1625. (a) The Secretary may make grants for construction or modernization projects designed to (1) eliminate or prevent imminent safety hazards as defined by Federal, State, or local fire, building, or life safety codes or regulations, or (2) avoid noncompliance with State or voluntary licensure or accreditation standards. A grant under this subsection may only be made to a State or political subdivision of a State, including any city, town, county, borough, hospital district authority, or public or quasi-public corporation, for a project described in the preceding sentence for any medical facility owned or operated by it.

"(b) An application for a grant under subsection (a) may not be approved under section 1604 unless it contains assurances satisfactory to the Secretary that the applicant making the application would not be able to complete the project for which the application is submitted without the grant applied for.

"(c) The amount of any grant under subsection (a) may not exceed 75 per centum of the cost of the project for which the grant is made unless the project is located in an area determined by the Secretary to be an urban or rural poverty area, in which case the grant may cover up to 100 per centum of such costs.

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"(d) Of the sums appropriated under section 1613 for a fiscal year, there shall be made available for grants under subsection (a) for such fiscal year 22 per centum of such sums.

"Part E—General Provisions

"JUDICIAL REVIEW

"Sec. 1630. If—

42 USC

"(1) the Secretary refuses to approve an application for a project submitted under section 1604, the State Agency through which such application was submitted, or

"(2) any State is dissatisfied with, or any entity will be adversely affected by, the Secretary's action under section 1612, such State or entity,

may appeal to the United States court of appeals for the circuit in which such State Agency, State, or entity is located, by filing a petition with such court within sixty days after such action. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Secretary, or any officer designated by him for that purpose. The Secretary thereupon shall file in the court the record of the proceedings on which he based his action, as provided in section 2112 of title 28, United States Code. Upon the filing of such petition, the court shall have jurisdiction to affirm the action of the Secretary or to set it aside, in whole or in part, temporarily or permanently, but until the filing of the record, the Secretary may modify or set aside his order. The findings of the Secretary as to the facts, if supported by substantial evidence, shall be conclusive, but the court, for good cause shown, may remand the case to the Secretary to take further evidence, and the Secretary may thereupon make new or modified findings of fact and may modify his previous action, and shall file in the court the record of the further proceedings. Such new or modified findings of fact shall likewise be conclusive if supported by substantial evidence. The judgment of the court affirming or setting aside, in whole or in part, any action of the Secretary shall be final, subject to review by the Supreme Court of the United States upon certiorari or certification as provided in section 1254 of title 28, United States Code. The commencement of proceedings under this section shall not, unless so specifically ordered by the Court, operate as a stay of the Secretary's action.

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"RECOVERY

"Sec. 1631. (a) If any facility constructed, modernized, or converted with funds provided under this title is, at any time within twenty years after the completion of such construction, modernization, or conversion with such funds—

42 USC 3

"(1) sold or transferred to any person or entity (A) which is not qualified to file an application under section 1601, or (B) which is not approved as a transferee by the State Agency of the State in which such facility is located, or its successor; or

ty, and the Secretary has not
mined that there is good cause for termination of such use, the United States shall be entitled to recover from either the transferor or the transferee in the case of a sale or transfer or from the owner in the case of termination of use an amount bearing the same ratio to the then value (as determined by the agreement of the parties or by action brought in the district court of the United States for the district in which the facility is situated) of so much of such facility as constituted an approved project or projects, as the amount of the Federal participation bore to the cost of the construction, modernization, or conversion of such project or projects. Such right of recovery shall not constitute a lien upon such facility prior to judgment.

Waiver.

"(b) The Secretary may waive the recovery rights of the United States under subsection (a) with respect to a facility in any State—

"(1) if (as determined under regulations prescribed by the Secretary) the amount which could be recovered under subsection (a) with respect to such facility is applied to the development, expansion, or support of another medical facility located in such State which has been approved by the Statewide Health Coordinating Council for such State as consistent with the State health plan established pursuant to section 1524(c); or

Ante, p. 2247.

"(2) if the Secretary determines, in accordance with regulations, that there is good cause for waiving such requirement with respect to such facility.

If the amount which the United States is entitled to recover under subsection (a) exceeds 90 per centum of the total cost of the construction or modernization project for a facility, a waiver under this subsection shall only apply with respect to an amount which is not more than 90 per centum of such total cost. The Secretary may not waive a right of recovery which arose one year before the date of the enactment of this title.

"STATE CONTROL OF OPERATIONS

2 USC 300s-2.

"SEC. 1632. Except as otherwise specifically provided, nothing in this title shall be construed as conferring on any Federal officer or employee the right to exercise any supervision or control over the administration, personnel, maintenance, or operation of any facility with respect to which any funds have been or may be expended under this title.

"DEFINITIONS

2 USC 300s-3.

"SEC. 1633. For the purposes of this title—

"(1) The term 'State' includes the Commonwealth of Puerto Rico, Guam, American Samoa, the Trust Territory of the Pacific Islands, the Virgin Islands, and the District of Columbia.

"(2) The term 'Federal share' means the proportion of the cost of a medical facilities project which the State Agency determines the Federal Government will provide under allotment payments or a loan or loan guarantee under this title, except that—

"(A) in the case of a modernization project—

"(i) described in section 1604(b)(2)(B), and

"(ii) the application for which received a waiver under section 1604(b)(2)(A),

the proportion of the cost of such project to be paid by the Federal Government under allotment payments or a loan may not exceed $20,000 and may not exceed 100 per centum of the first $6,000 of the cost of such project and 66⅔ per centum of the next $21,000 of such cost,

"(B) in the case of a project (other than a project described in subparagraph (A)) to be assisted from an allotment made under part B, the proportion of the cost of such project to be paid by the Federal Government may not exceed 66⅔ unless the project is located in an area determined by the Secretary to be an urban or rural poverty area, in which case the proportion of the cost of such project to be paid by the Federal Government may be 100 per centum, and

"(C) in the case of a project (other than a project described in subparagraph (A)) to be assisted with a loan or loan guarantee made under part C, the principal amount of the loan directly made or guaranteed for such project, when added to any other assistance provided the project under this title, may not exceed 90 per centum of the cost of such project unless the project is located in an area determined by the Secretary to be an urban or rural poverty area, in which case the principal amount, when added to other assistance under this title, may cover up to 100 per centum of the cost of the project.

"(3) The term 'hospital' includes general, tuberculosis, and other types of hospitals, and related facilities, such as laboratories, outpatient departments, nurses' home facilities, extended care facilities, facilities related to programs for home health services, self-care units, and central service facilities, operated in connection with hospitals, and also includes education or training facilities for health professional personnel operated as an integral part of a hospital, but does not include any hospital furnishing primarily domiciliary care.

"(4) The term 'public health center' means a publicly owned facility for the provision of public health services, including related publicly owned facilities such as laboratories, clinics, and administrative offices operated in connection with such a facility.

"(5) The term 'nonprofit' as applied to any facility means a facility which is owned and operated by one or more nonprofit corporations or associations no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual.

"(6) The term 'outpatient medical facility' means a medical facility (located in or apart from a hospital) for the diagnosis or diagnosis and treatment of ambulatory patients (including ambulatory inpatients)—

"(A) which is operated in connection with a hospital,

"(B) in which patient care is under the professional supervision of persons licensed to practice medicine or surgery in the State, or in the case of dental diagnosis or treatment, under the professional supervision of persons licensed to practice dentistry in the State; or

"(C) which offers to patients not requiring hospitalization the services of licensed physicians in various medical specialties, and which provides to its patients a reasonably full-range of diagnostic and treatment services.

"(7) The term 'rehabilitation facility' means a facility which is operated for the primary purpose of assisting in the rehabilitation of disabled persons through an integrated program of—

"(A) medical evaluation and services, and

"(B) psychological, social, or vocational evaluation and services,

under competent professional supervision, and in the case of which the major portion of the required evaluation and services is furnished within the facility; and either the facility is operated in connection with a hospital, or all medical and related health services are prescribed by, or are under the general direction of, persons licensed to practice medicine or surgery in the State,

facility for long-term care' means a facility (including a skilled nursing or intermediate care facility) providing in-patient care for convalescent or chronic disease patients who required skilled nursing or intermediate care and related medical services—

"(A) which is a hospital (other than a hospital primarily for the care and treatment of mentally ill or tuberculous patients) or is operated in connection with a hospital, or

"(B) in which such care and medical services are prescribed by, or are performed under the general direction of, persons licensed to practice medicine or surgery in the State.

"(9) The term 'construction' means construction of new buildings and initial equipment of such buildings and, in any case in which it will help to provide a service not previously provided in the community, equipment of any buildings; including architects' fees, but excluding the cost of off-site improvements and, except with respect to public health centers, the cost of the acquisition of land.

"(10) The term 'cost' as applied to construction, modernization, or conversion means the amount found by the Secretary to be necessary for construction, modernization, or conversion, respectively, under a project, except that, in the case of a modernization project or a project assisted under part D, such term does not include any amount found by the Secretary to be attributable to expansion of the bed capacity of any facility. 2, p. 2268.

"(11) The term 'modernization' includes the alteration, expansion, major repair (to the extent permitted by regulations), remodeling, replacement, and renovation of existing buildings (including initial equipment thereof), and the replacement of obsolete equipment of existing buildings.

"(12) The term 'title,' when used with reference to a site for a project, means a fee simple, or such other estate or interest (including a leasehold on which the rental does not exceed 4 per centum of the value of the land) as the Secretary finds sufficient to assure for a period of not less than twenty-five years' undisturbed use and possession for the purposes of construction, modernization, or conversion and operation of the project for a period of not less than (A) twenty years in the case of a project assisted under an allotment or grant under this title, or (B) the term of repayment of a loan made or guaranteed under this title in the case of a project assisted by a loan or loan guarantee.

"(13) The term 'medical facility' means a hospital, public health center, outpatient medical facility, rehabilitation facility, facility for long-term care, or other facility (as may be designated by the Secretary) for the provision of health care to ambulatory patients.

"(14) The term 'State Agency' means the State health planning and development agency of a State designated under title XIV. SC 1351.

"(15) The term 'urban or rural poverty area' means an urban or rural geographical area (as defined by the Secretary) in which a percentage (as defined by the Secretary in accordance with the next sentence) of the residents of the area have incomes below the poverty level (as defined by the Secretary of Commerce). The percentage referred to in the preceding sentence shall be defined so that the percentage of the population of the United States residing in urban and rural poverty areas is—

"(A) not more than the percentage of the total population of the United States with incomes below the poverty level (as so defined) plus five per centum, and

"(B) not less than such percentage minus five per centum.

"(16) The term 'medically underserved population' means the population of an urban or rural area designated by the Secretary as an area with a shortage of health facilities or a population group designated by the Secretary as having a shortage of such facilities.

"FINANCIAL STATEMENTS; RECORDS AND AUDIT

"Sec. 1634. (a) In the case of any facility for which an allotment payment, grant, loan, or loan guarantee has been made under this title, the applicant for such payment, grant, loan, or loan guarantee (or, if appropriate, such other person as the Secretary may prescribe) shall file at least annually with the State Agency for the State in which the facility is located a statement which shall be in such form, and contain such information, as the Secretary may require to accurately show— 42 USC 3

"(1) the financial operations of the facility, and

"(2) the costs to the facility of providing health services in the facility and the charges made by the facility for providing such services,

during the period with respect to which the statement is filed.

"(b)(1) Each entity receiving Federal assistance under this title shall keep such records as the Secretary shall prescribe, including records which fully disclose the amount and disposition by such entity of the proceeds of such assistance, the total cost of the project in connection with which such assistance is given or used, the amount of that portion of the cost of the project supplied by other sources, and such other records as will facilitate an effective audit. Record-keeping.

"(2) The Secretary and the Comptroller General of the United States, or any of their duly authorized representatives, shall have access for the purpose of audit and examination to any books, documents, papers, and records of such entities which in the opinion of the Secretary or the Comptroller General may be related or pertinent to the assistance referred to in paragraph (1). Audit.

"(c) Each such entity shall file at least annually with the Secretary a statement which shall be in such form, and contain such information, as the Secretary may require to accurately show—

"(1) the financial operations of the facility constructed or modernized with such assistance, and

"(2) the costs to such facility of providing health services in such facility, and the charges made for such services, during the period with respect to which the statement is filed.

"TECHNICAL ASSISTANCE

"Sec. 1635. The Secretary shall provide (either through the Department of Health, Education, and Welfare or by contract) all necessary technical and other nonfinancial assistance to any public or other nonprofit entity which is eligible to apply for assistance under this title to assist such entity in developing applications to be submitted to the Secretary under section 1604. The Secretary shall make every effort to inform eligible applicants of the availability of assistance under this title. 42 USC 30

"Part F—Area Health Services Development Funds

"DEVELOPMENT GRANTS FOR AREA HEALTH SERVICES DEVELOPMENT FUNDS

"Sec. 1640. (a) The Secretary shall make in each fiscal year a grant to each health system agency— 42 USC 30

"(1) with which there is in effect a designation agreement under section 1515(c),

"(2) which has in effect an HSP and AIP reviewed by the Statewide Health Coordinating Council, and Ante, p.

Ante, p. 2255.

"(3) which, as determined [illegible] the manner prescribed [illegible] section 1512(b) and is performing its functions under section 1513 in a manner satisfactory to the Secretary,

Ante, p. 2235.

to enable the agency to establish and maintain an Area Health Services Development Fund from which it may make grants and enter into contracts in accordance with section 1513(c)(3).

"(b)(1) Except as provided in paragraph (2), the amount of any grant under subsection (a) shall be determined by the Secretary after taking into consideration the population of the health service area for which the health systems agency is designated, the average family income of the area, and the supply of health services in the area.

Limitation.

"(2) The amount of any grant under subsection (a) to a health systems agency for any fiscal year may not exceed the product of $1 and the population of the health service area for which such agency is designated.

"(c) No grant may be made under subsection (a) unless an application therefor has been submitted to, and approved by, the Secretary. Such an application shall be submitted in such form and manner and contain such information as the Secretary may require.

ppropriations.

"(d) For the purpose of making payments pursuant to grants under subsection (a), there are authorized to be appropriated $25,000,000 for the fiscal year ending June 30, 1975, $75,000,000 for the fiscal year ending June 30, 1976, and $120,000,000 for the fiscal year ending June 30, 1977."

MISCELLANEOUS AND TRANSITIONAL PROVISIONS

ppropriations.
2 USC 300m
ote.
2 USC 246.

SEC. 5. (a)(1) There are authorized to be appropriated for the fiscal year ending June 30, 1975, and the next fiscal year such sums as may be necessary to make grants under section 314(a) of the Public Health Service Act, except that no grant made to a State with funds appropriated under this paragraph shall be available for obligation beyond—

nte, p. 2242.

(A) three months after the date on which a State health planning and development agency is designated for such State under section 1421 of such Act, or

(B) June 30, 1976,

whichever is later.

2 USC 300l-4
ote.
2 USC 242b.
2 USC 299.

(2) There are authorized to be appropriated for the fiscal year ending June 30, 1975, and the next fiscal year such sums as may be necessary to make grants under section 304 of the Public Health Service Act for experimental health services delivery systems, section 314(b) of such Act, and title IX of such Act, except that no grant made with funds appropriated under this paragraph shall be available for obligation beyond the later of (A) June 30, 1976, or (B) three months after the date on which a health systems agency has been designated under section 1415 of such Act for a health service area which includes the area of the entity for which a grant is made under such section 304, 314(b), or title IX.

2 USC 291b
ote.
2 USC 291a.

(b) Any State which has in the fiscal year ending June 30, 1975, or the next fiscal year funds available for obligation from its allotments under part A of title VI of the Public Health Service Act may in such fiscal year use for the proper and efficient administration during such year of its State plan approved under such part an amount of such funds which does not exceed 4 per centum of such funds or $100,000, whichever is less.

(e) A reference in any law or regulation—

42 USC
note.

(1) to the agency of a State which administers or supervises the administration of a State's health planning functions under a State plan approved under section 314(a) of the Public Health Service Act shall in the case of a State for which a State Health planning and development agency has been designated under section 1521 of such Act be considered a reference to the State agency designated under such section 1521;

42 USC
Ante, p

(2) to an agency or organization which has developed a comprehensive regional, metropolitan, or other local area plan or plans referred to in section 314(b) of the Public Health Service Act shall if all or part of the area covered by such plan or plans is within a health service area established under section 1511 of the Public Health Service Act be considered a reference to the health systems agency designated under section 1515 of such Act for such health service area; and

42 USC
note.
Ante, p
Ante, p

(3) to a regional medical program assisted under title IX of the Public Health Service Act shall if the program is located in a State for which a State health planning and development agency has been designated under section 1521 of the Public Health Service Act be considered a reference to such State agency.

42 USC
note.
42 USC

(d) Section 516 of the Public Health Service Act is repealed.

Repeal.
42 USC

ADVISORY COMMITTEE

SEC. 6. (a) An advisory committee established by or pursuant to the Public Health Service Act, the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 shall terminate at such time as may be specifically prescribed by an Act of Congress enacted after the date of the enactment of this Act.

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42 USC
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42 USC

(b) The Secretary of Health, Education, and Welfare shall report, within one year after the date of the enactment of this Act, to the Committee on Labor and Public Welfare of the Senate and the Committee on Interstate and Foreign Commerce of the House of Representatives (1) the purpose and use of each advisory committee established by or pursuant to the Public Health Service Act, the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 and (2) his recommendations respecting the termination of each such advisory committee.

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AGENCY REPORTS

SEC. 7. The Secretary of Health, Education, and Welfare shall report, within one year of the date of the enactment of this Act, to the Committee on Labor and Public Welfare of the Senate and the Committee on Interstate and Foreign Commerce of the House of Representatives (1) the identity of each report required to be made by the Secretary under the Public Health Service Act, the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 to the Congress (or any committee thereof), (2) the provision of such Acts which requires each such report, (3) the purpose of each such report, and (4) the due date for each such report. The report of the

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42 USC 2
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Secretary under this section may include such recommendations as he considers appropriate for termination or consolidation of any such reporting requirements.

TECHNICAL AMENDMENT

42 USC 300e-4.

SEC. 8. Section 1305(b)(1) of the Public Health Service Act is amended to read as follows:

"(b)(1) Except as provided in paragraph (2), the aggregate amount of principal of loans made or guaranteed, or both, under this section for a health maintenance organization may not exceed $2,500,000. In any fiscal year, the amount disbursed under a loan or loans made or guaranteed under this section for a health maintenance organization may not exceed $1,000,000,000."

Approved January 4, 1975.

LEGISLATIVE HISTORY:

HOUSE REPORTS: No. 93-1382 accompanying H.R. 16204 (Comm. on Interstate and Foreign Commerce) and No. 93-1640 (Comm. of Conference).
SENATE REPORT No. 93-1285 (Comm. on Labor and Public Welfare).
CONGRESSIONAL RECORD, Vol. 120 (1974):
Nov. 25, considered and passed Senate.
Dec. 13, considered and passed House, amended, in lieu of H.R. 16204.
Dec. 19, Senate agreed to conference report.
Dec. 20, House agreed to conference report.

○

APPENDIX C: THE CONNECTICUT HEALTH PLANNING SYSTEM

PART I: SCC/CHP ADVISORY COUNCIL

PART II: CRMP ADVISORY BOARD

PART III: NHHC DIRECTORS

PART IV: SCC/CHP TRANSITION COMMITTEE

PART V: NHHC TRANSITION COMMITTEE

C/P	Name Home Address Telephone	Occupation Business Address Telephone	Term Expires	Area	Memberships	Representing
P	*Susan Addiss 92 Mansfield Street New Haven, Ct. 06511	Health Director #LNV District Health Dpt. Plaza-on-the-Green Derby, Conn. 735-9548	'75	LNV	Planned Parenthood of GNH LEAP Heart Assoc. of GNH CHP - Health Plan Committee Trustee of Griffin Hospital Member of CPHA Secy. - Conn. Assoc. of Health Directors - Full Time Ex-Officio Board member of Public Hlth Nursing and Homemakers Service, Inc. (LNV)	LNV District Health Dept.
C	Gretchen Aherne 10 Dorian Drive East Haven, Conn. 06512 469-9798		'75	GNH	East Shore Health Planning Advisory Council (CHP) East Shore Advocates for Mental Health East Shore District Health Department (Board) So. Central MHPC (Vice-President) Health Plan Committee (CHP)	Town of East Haven
C	* Roberta Ahlberg # 413 Village St. Northford, Ct. 06471	Secretary New Haven Savings Bank 170 Orange St. New Haven, Conn. 787-1111	'75	GNH	No. Branford Women's Club Assoc. of Savings Banks East Shore Health Planning Advisory Council (CHP)	Town of North Branford
P	Frank Allen PO Box 139 Seymour, Ct. 06483	Housing Code Enforcement Officer #Town Hall Annex Seymour, Ct. 06483 888-5661	'75	LNV	LNV Community Council	Town of Seymour

C	Harold Allen West Haven, Ct. 06515 934-3421	321 Indian River Rd. Orange, Ct. 06477			City of West Haven	City of West Haven
P	*Ida Arbitman 851 Edgewood Ave. New Haven, Ct. 06515 389-5032	Coordinator #Elderly Nutritional Planning of So. Central Connecticut Univ. of New Haven 300 Orange Ave. West Haven, Ct. 06510 934-6321	'77	GNH	National Council of Aging Conn. Recreation and Parks Association Board Member, Conn. Society of Gerontology	Senior Citizens GNH
P	Vera Arterburn 53 Morningside Drive Milford, Conn. 06460 878-2977	Executive Secretary #Ct. Assoc. of Extended Care Facilities 102 Elm St. West Haven, Ct. 06516 933-2535	'77	GNH	American College of Nursing Home Administrators American Nursing Home Assn. American Society of Association Executives Gerontological Society Yale New Haven Continuing Care Committee Health Plan Committee (CHP)	Conn. Assoc. of Extended Care Facilities
C	* Thayer Baldwin Jr. 151 Livingston St. New Haven, Ct. 06511 624-3443	Attorney # Baldwin & Lieberman 152 Temple St. New Haven, Ct. 06510 787-0151	'76	GNH	Treasurer of & Board of Business Resources Center, Inc. Democratic Town Committee Board of Cooperative Consumers of New Haven, Inc. Board - New Haven Water Co. Environmental Task Force (CHP)	Undesignated
P	Harold Batt, M.D. # 175 Whittier Rd. New Haven, Ct. 06515 288-7975	Physician 121 Wakelee Ave. Ansonia, Ct. 06401 777-5447	'77	LNV	Naugatuck Valley Medical Society Conn. Medical Society New Haven County Medical Society American Cancer Society	Naugatuck Valley Medical Society
P	* Richard Benfer 832 Cornwall St. Cheshire, Ct. 272-4905	Asst. Administrator # Hospital of St. Raphael 1450 Chapel St. New Haven, Ct. 772-3900	'75	GNH	Hospital Cooperative Services New Haven Institute of Allied Health Conn. Hospital Association Council on Government Relations Health Plan Committee (CHP)	Community Hospitals

	#238 Prospect St. New Haven, Ct. 06511 624-9319		'75	M-O	Council of Youth (SSC) M-O Committee (CHP) Health Plan Committee	Youth - M-O
C	Maycerine Bonner 21 Garden St. New Haven, Ct. 777-5230		'76	GNH	United Newhallville Org.	Newhallville Neighborhood
C	Marion Cafasso 20 Grandview Blvd. Derby, Ct. 06418 734-7502		'75	LNV		City of Derby
C	*Ismael Chavez # 45 Fairfield St. New Haven, Ct. 389-1314	Community Relations Yale New Haven Hospital 789 Howe St. New Haven, Ct.	'77	GNH	Junta Health Plan Committee (CHP)	Junta
P	Patricia Conte 22 Sportsman Hill Madison, Ct. 06443 245-1827	Supervisor - Madison Public Health Nursing 14 Meetinghouse Lane Madison, Ct. 245-0436	'75	GNH	Conn. League of Nurses ESAMH	Town of Madison
C	*Edward Cowey 37 Perry Hill Road Shelton, Ct. 06484 734-1427	Retired	'75	LNV	Griffin Hospital Trustee LNV Public Hlth. Nursing & Homemakers Service Inc. Lung Assoc. of So. Central Conn. Hospital Assoc. NE Hospital Assembly	City of Shelton
C	Louise DeLauro 538 Chapel St. New Haven, Ct. 06511 865-8052	Clerk of Probate Court 161 Church St. New Haven, Ct. 787-2118	'76	GNH	Wooster Square Neighborhood Democratic Town Committee Alderman - City of New Haven Mayor's Committee on Elderly	Wooster Square Neighborhood

	Roberta Rd. North Haven, Ct. 06473 239-0496		75	GNH	North Four Committee (CHP) Commission on Aging Conn. Stroke Program	Town of North Haven
PM	*Marcia Fink 58 Stone Manor Dr. Milford, Ct. 06460 878-5498		'76	M-O	M-O Health Planning Committee (CHP) Review Committee (CHP) Environmental Task Force (CHP)	M-O Component Committee
P	Henrietta Forman 172 Colony Road New Haven, Cy. 06511 777-3982	Pharmacist	'77	GNH	President, New Haven County Pharmaceutical Assoc. Conn. Pharmaceutical Assoc. Community Pharmacist Committee	New Haven County Pharmaceutical Assoc.
P	Marvin Fox, M.D.	Physician 122 Broad St. Milford, Ct. 06460 878-3533	'77	M-O	President, Milford Medical Soc.	Milford Medical Society
P	*Russell Fuldner, M.D.	Physician 178 Sherman Ave. New Haven, Ct. 06511 865-3063	'77	GNH	Medical Advisory Council N.H. County Medical Society New Haven Rehabilitation Soc.	New Haven County Medical Society
C	~~Louise Gordon~~ ~~206 Armory St.~~ ~~Hamden, Ct. 06511~~ ~~776-9321~~		~~'76~~	~~GNH~~	~~Yale N.H. Hospital Board~~ ~~New Haven Foundation - Distribution Committee~~ ~~CRMP - Board~~	Conn. Regional Medical Program
C	*Richard M. Grave Moose Hill Road Guilford, Ct. 06436 433-5555	Manufacturer #FD Grave & Son 210 State St. New Haven, Ct. 06510 624-9893	'76	GNH	State Advisory Council for CHP	Decision Maker
C	Peter Gray	Executive Director #Dixwell Neighborhood Corp. 226 Dixwell Ave. New Haven, Ct. 06511 562-2178	'76	GNH	Mayor's Task Force on Drugs (New Haven)	Dixwell Neighborhood Corp.

	215 Hartford Tpke. Hamden, Ct. 06517 248-3050 Summer Address: 23 Groveway Clinton, Ct. 06413 669-2761	Housewife	'76	GNH	North Four Committee (CHP) Health Plan Committee (CHP)	Public Health Nursing
C	*Audrey Heusser 62 Howe St. Shelton, Ct. 06484 734-8518	Writer	'75	LNV	Boards of: Public Health Nursing & Homemaker Service LNV Valley United Way - Chairman President - LNV Community Council Griffin Hospital - Trustee New Haven Area Heart Assoc. - Public Relations Committee League of Women Voters - Tri-State Metropolitan Area Mass Transportation. Chairman - Board of Zoning Appeals (Shelton).	Homemaker Services LNV
P	*Raymond Higgins 32 Spring St. Milford, Ct. 878-3830	Health Administrator Division of Environmental Health Milford Health Dept. Eels Hill Road Milford, Ct. 06460 878-1731 x61	'77	M-O	Health Plan Committee (CHP) Environmental Task Force (CHP)	Milford Health Department
P	*Aaron Hornstein, DDS 51 Robinwood Road Hamden, Ct. 562-5033	Dentist #1172 Whitney Ave. Hamden, Ct. 06517 562-7324	'76	GNH	Conn. Dental Society Treas. Morton J. Loeb Dental Soc. Affiliated with UConn Dental School (Admissions)	Conn. Dental Society
C	Luci Iannotti 20 Wilton Road Hamden, Ct. 06517 787-3059		'77	GNH	Board of Children's Center	Family & Children's Services

	6 Harbor View Branford, Ct. 06405 488-4164	#124 East Main St. Branford, Ct. 06405 488-9463	'75	GNH	Conn. Chiropractic Assoc.	Undesignated
C	*Esther Jamieson #152 Norton St. New Haven, Ct. 06511 787-3688	Assistant Manager West Project New Haven Housing Authority 230 Ashman St. New Haven, Ct. 06511 777-7631	'77	GNH	So. Central Conn. Regional Mental Health Planning Council	SCCRMHPC
PM	*Leroy Jones 470 Whitney Ave. New Haven, Ct. 06511 787-3984	Development Adminis. #City Hall 161 Church St. New Haven, Ct. 06510 436-8050	'77	GNH	Nat'l. Assoc. Housing & Redevelopment Officials Rotary American Society Planning Officials American and State Bar Associations	City of New Haven
C	John Kelly 18 Henry St. Seymour, Ct. 06483 888-9454	Manager of Engineering #Marlin Firearms Co. Kenna Drive North Haven, Ct. 239-5621	'77	LNV	Valley Regional Planning Agency	LNV Regional Planning Agency
P	John J. Kennedy 488 Wildwood Dr. Orange, Ct. 06477	Vice-President and Secretary #Conn. Blue Cross 370 Bassett Rd. North Haven, Ct. 06473 239-4911	'76	GNH	Board of Directors, Conn. Chptr. American Red Cross, Congressional Action Committee & Regional Affairs Committee, GNH Chamber of Commerce Service Committee, American Cancer Soc. Board of Directors, Hartford County Health Care Plan Steering Committee, Conn. Family Health Plan United Community Services Comprehensive Health Planning Agency (Bridgeport) Conn. Hospital Association Blue Cross Association National Marketing	Health Insuror

	Rev. Lawrence Larson 38 Mott St. Ansonia, CT.	same	'77	LNV - M-O	LNV CAP Agency Budget Committee - United Way of LNV Clergy Association	Comm. Action - Aging M-O, LNV
C	~~*Pearl Leslie~~ ~~#5 Trade Union Plaza~~ ~~New Haven, Ct. 06511~~	Resigned - see attached list for replacement	'76	GNH	Dwight Neighborhood Corp. Chairman New Professionals of this Region Environmental Task Force	Dwight Neighborhood
PM	*Ann LoPresti 852 So. Main St. Seymour, Connecticut 734-6869	First Selectwoman #Town of Seymour 1 First St. Seymour, Ct. 888-2521	'77	LNV	Democratic Town Committee Retired Teacher's Association Conn. Education Association Seymour Democratic Women's Club	Council of Governments LNV
C	VICE CHAIRMAN Resigned - see attached list for replacement ~~* Rev. Dwight Lundgren~~ ~~#339 Shelton Ave.~~ ~~Shelton, Ct. 06484~~ ~~929-6246~~	~~Minister~~ ~~First Baptist Church~~ ~~178 Leavenworth Rd.~~ ~~Shelton, Ct.~~	~~'77~~	~~LNV~~	~~LNV Mental Health Planning Council~~	LNV MHPC
C	Joseph A. McAlpine 721 Orchard St. New Haven, Ct. 06511 624-4775	Supervisor #Community Relations So. Conn. Gas Co. 80 Crown St. New Haven, Ct. 772-1150 x251	'75	GNH	Chairman, Hannah Gray Home Dixwell Community House Board of Directors Urban League - B.D. Chairman - Employment United Way - Planning Council Comm. Friends of S. Central Community College	United Way GNH
P	CHAIRMAN *Marcus McCraven 565 W. Shepard Ave. Hamden, Ct. 06518 288-1721	Dir. Environmental Engineering #United Illuminating Co. 80 Temple St. New Haven, Ct. 777-7981	'76	GNH	Commissioner of Hamden Planning & Zoning Commission Director of New England Section of Air Pollution Control Assn. Director Jr. Achievement of GNH Member, Environmental Science & Technological Commission of Conn. Business & Industry Assoc. Board of Trustees, State Colleges Chairman - CHP	GNH Component Committee

	91 Old Quarry Rd. Guilford, Ct.	retired	'77	GNH		Town of Guilford
P	*Dennis Mesenheimer PO Box 61 Norwich, Ct.	Executive Director #Heart Assoc. of GNH 1184 Chapel St. New Haven, Ct. 06511 777-6465	'77	GNH	(CHAD) Combined Health Agency Drive	Voluntary Health Agencies
P	Doris Morrison 34 lines St. New Haven, Ct. 06519 776-7906	Caseworker #Family Counseling One State St. New Haven, Ct. 06511 865-1125	'77	GNH	Dixwell Planning Team Hill Planning Team Black Coalition Black Caucus of FAmily Service Assoc. of America-Executive Comm. Urban League NAACP Nat. Assoc. Black Social Workers Steering Committee	Undesignated
C	TREASURER *William Nyhan 1 Club Rd. Orange, Ct. 06477 799-2217	Management Engineer #Armstrong Rubber 500 Sargent Drive New Haven, Ct. 06511 777-7401 x279	'76	M-O	President, Armstrong Rubber Federal Credit Union Member Orange Town Democratic Commission Member Orange Parks and Recreation Commission M-O Health Planning Com (CHP) Treasurer (CHP)	M-O Component Area
P	~~Leonard Parente, M.D.~~ ~~185 Braeside Drive~~ ~~Hamden, Ct. 06514~~ ~~248-5955~~	~~Director of Health~~ ~~#Town of Hamden~~ ~~Memorial Town Hall~~ ~~Hamden, Ct. 06518~~ ~~288-5641~~	~~'77~~	~~GNH~~	~~State Advisory Council CHP~~ ~~Advisory Public Health Committee (CRMP)~~ ~~Hamden Branch American Red Cross~~ ~~Lung Assoc. of S.C.~~ ~~State TB Assoc.~~ ~~Air Conservation Committee~~	~~Health Director~~
C	Thomas Parsons 10 Overton Ave. Milford, Ct. 874-1140	President T.C. Parsons Office Equipemnt Co. #400 Boston Post Rd. Milford, Ct. 06460 878-0623	'75	M-O	Member Milford Republican Town Committee President, Milford Rotary American Red Cross, Milford Homemaker Service of Milford, B.D.	City of Milford

					Treasurer, Milford CDAP Chairman Economic Business Industrial Dev. Commission, City of Milford	
C	*Charles Perry Jr. 17 1/2 Star St. Ansonia, Ct. 06401	Director #Community Action, Inc. 183 No. Main St. Ansonia, Ct. 06401 735-8592	'77	LNV	Community Action, Inc. LNV Citizen Action League LNV Mental Health Planning Council Ad Hoc Human Rights Committee on Legislation Health Plan Committee (CHP)	LNV Black Community
C	Penelope Pigott #188 Wildwood Ave. Madison, Ct. 06443 245-1004	Yale Office of Institutional Development Yale News Bureau 149 York St. New Haven, Ct. 436-3344	'76	GNH	League of Women Voters - Board	GNH Component Area
P	Carl V. Puleo 51 Pembroke Rd. Hamden, Ct. 06514 248-7787	Exec. Director #Goodwill Easter Seals Rehabilitation Center 20 Brookside Ave. New Haven, Ct. 06515 389-4561	'77	GNH	Board of Advisors - WHEE (We Help Elders Establish Employmt) Chairman - Hamden Committee on Needs of Aging Rotary Conn. Rehabilitation Assoc. - Past President NH Chapter - Governor's Committee on Employment of the Handicapped Nat'l Rehabilitation Association Mt. Carmel Art Association Society of Conn. Craftsmen Conn. Internat'l Assoc. of Rehab. Facilities.	Rehabilitation Services
P	Robert Reynolds, DDS 189 Glen Pkwy Hamden, Ct. 06517 288-1782	Dentist #1828 Dixwell Ave. Hamden, Ct. 06514 248-2429	'75	GNH	Town of Hamden	Town of Hamden
C	* Marcia Richardson # Arthur Road No. Branford, Ct. 06471 484-9918	Secretary Yale U. Dept. of EPH 60 College St. New Haven, Ct. 436-2423	'77	GNH	Regional Planning Agency of So. Central Conn. League of Women Voters Conn. Trails of Girl Scouts	Regional Planning Agency of SCC

874-3830

Citizens M-O

C	Joseph Roberts	President Edgecomb-Milford Inc. 950 Bridgeport Ave. Milford, Ct. 06460 874-1631	'75	M-O	Milford Hospital Board M-O Health Planning Committee	Decision Maker
P	Benjamin Rosenthal, M.D. 196 Pond Point Ave. Milford, Ct. 878-2367	Director of Health #City of Milford Milford, Ct. 06460 878-1731	'77	GNH	President - Milford Rotary Milford Medical Society	Milford Health Director
P	SECRETARY *Isabel Russell One Dixwell Plaza New Haven, Ct. 06511	Community Liason Worker #Family Planning 46 Webster St. New Haven, Ct. 06511 776-8763	'75	GNH	United Way of GNH Black Coalition	Undesignated
C	Marion Russell 125 Millbrook Rd. North Haven, Ct. 288-8835		'77	GNH	Homemaker's Services	Homemaker's Services GNH
C	*Elvera Serio 189 E. Grand Ave. New Haven, Ct. 06513 469-9817	Vista Volunteer PR Work Fair Haven Health Clinic 388 Grand Ave. New Haven, Ct. 06513 777-3704	'76	GNH	Chairman of Special Projects Committee - Benjamin Jepson School Council 71-73 Bd. of Fair Haven Community Health Clinic 71-73 Member and Founder of Mother's Coop Nursery 68-70 Health Outreach Worker, Fair Haven Neighborhood Corp. Young Women's Republican Club	Fair Haven Neighborhood
C	Charlotte Smith Bethmore Rd. Bethany, Ct. 393-3349	Retired	'75	GNH	Regional VNA Conn. Public Health Assn. New Haven Public Health Assn. North Four Committee (CHP)	Town of Bethany

	217 Leete 488-4892	Guilford, Ct. 453-4386			Water Pollution Control Association Conn. Society of Civil Engineers National Society of Professional Engineers Review Committee (CHP) Environmental Task Force (CHP)	Environmental Health
P	*Paul Taylor, O.D. 89 Rayzoe Terrace Hamden, Ct. 06514 288-2188	Optometrist #306 Dixwell Ave. New Haven, Ct. 06511 562-3202	'76	GNH	Hamden Board of Education Conn. Optometric Society National Optometric Society-Pres. American Optometric Society New Haven Optometric Society New Haven Health Care Board	Undesignated
C	*Beatrice Torrenti 141 Old Tavern Rd. Orange, Ct. 06477 795-4521		'75	M-O	Women's Republican Club of Orange Women's Guild-Holy Infant Church High Plains School PTA Auxilary-Hospital of St. Raphael	Town of Orange
C	Dorothea Verrett 936 Howe Ave. Shelton, Ct. 06484 734-9512	Retired	'77	LNV	Shelton Senior Citizen Commission Shelton League of Women Voters Griffin Hospital Auxilary Hewitt Memorial Hospital Auxilary Nat'l and State Teacher Associations National Wildlife	Senior Citizen LNV
P	Doris Wadley 81 Rockcreek New Haven, Ct. 06515 387-1464	Nurse	'76	GNH	West Rock Neighborhood Corp. Chairlady, Democratic Party City of New Haven	West Rock Neighborhood Corp.
P	Florence Waite 110 Asylum St. New Haven, Ct. 06519	Community Health Worker #Hill Health Center 428 Columbus Ave. New Haven, Ct. 06519 432-4600	'76	GNH	Hill Health Center Board Hill Neighborhood Corp.	Hill Neighborhood

	New Haven, Ct. 777-0439	#New Haven Health Dept. One State St. New Haven, Ct. 06511 562-0151 x1316				
C	Janet Wight 14 Corbin Circle Branford, Ct. 06405 488-2640		'75	GNH	Red Cross Volunteer	Town of Branford
P	*Courtland S. Wilson 266 Goffe Terrace New Haven, Ct. 06511 562-7977	Coordinator, Minority Recruitment #Yale New Haven Hsopital Room 220-BB 789 Howard Ave. New Haven, Ct. 06504 436-3797	'76	GNH	New Haven Black Coalition Visiting Nurse Assoc. New Haven Health Care New Haven Institute of Allied Careers Inc. Heritage Hall Development Corp. E.D. Formin, Inc. N.A.A.C.P. (New Haven Branch)	Black Coalition
P	Charles Womer Maplevale Drive Woodbridge, Ct. 06525 393-3324	Director #Yale New Haven Hospital 789 Howard Ave. Box 1001 New Haven, Ct. 06504 436-2761	'75	GNH	Conn. Regional Medical Program, Advisory Board Board of Conn. Hospital Assoc.	University Hospital
C	*Edmund Worfolk 874 Bayberry Lane Orange, Ct. 06477 795-9112	Retired	'76	LNV	Past President, LNV Community Council (73-74) Honorary Trustee of Griffin Hospital Review Committee (CHP) Health Care Cost Committee (CHP)	Decision Maker

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KEY:
# Denotes Mailing Address
* Denotes Board Member

LNV = Lower Naugatuck Valley
GNH = Greater New Haven
M-O = Milford - Orange

P = Provider
C = Consumer
PM = Public Member

ATTACHMENT C

CONNECTICUT REGIONAL MEDICAL PROGRAM

ADVISORY BOARD

Chairman

*Russell G. D'Oench, Jr.
Editor, Middletown Press;
Public Member

Vice-Chairman

*Frank T. Healey, Jr.
Attorney, Chairman,
Conference of Hospital
Trustees

Mrs. Margaret Alston, Vice
President Community Renewal
Team Inc., Hartford;
Public Member

*Robert W. Berliner, M.D.
Dean, Yale University
School of Medicine

Robert C. Boardman
Administrator, Rockville
General Hospital; Chairman, Conference of
Hospital Administrators

Gunar Bohan, M.D.
Director of Health,
City of Meriden; CHP
B Agency Representative

Mrs. V. Schroeder Burnham
Federal Consultant on Medical Affairs; Public Member

*Clarence Bushnell
Administrator, Bridgeport
Hospital; Connecticut
Hospital Association

Mrs. Arlyne Dildy
Housewife
Public Member

Joseph Duplinsky, President
Connecticut Blue Cross;
Public Member - Finance

*J. Alfred Fabro, M.D., Surgeon
Private Practice; Connecticut
State Medical Society

Donald S. Farrington
Northern and Southern Connecticut Chapters, National
Association of Social Workers

Stuart C. Finch, M.D.
Professor of Medicine,
Yale University School of
Medicine

Michael Fiskio, D.D.S.
General Dentistry
Connecticut State Dental
Association

J. Richard Gaintner, M.D.
Associate Dean for Clinical
Affairs, University of Connecticut School of Medicine

*Executive Committee Member

Chairman

*Russell [illegible]
Editor, [illegible]
Public [illegible]

Vice-Chairmen

*Frank W. [illegible]
Attorney [illegible]
Commission [illegible]
Trustee

Mrs. Margaret [illegible]
[illegible]
[illegible]
Public [illegible]

*Robert [illegible]
Dean, [illegible]
Federal [illegible]

Mrs. Eleanor Gill, R.N.
Dean, University of Connecticut School of Nursing;
Connecticut Nurses Association

Ralph Gofstein, M.D.
Director of Health
City of Stamford; CHP B
Agency Representative

*Orvan W. Hess, M.D.
Obstetrician-Gynecologist
Private Practice;
Connecticut State
Medical Society

John Ives, Director
University of Connecticut
Health Center Hospital

Stewart A. King, M.D.
Surgeon, Private Practice;
Connecticut Division,
American Cancer Society

Mrs. Karl Knollmueller, R.N.
Instructor, Yale School of
Nursing; Connecticut League
for Nursing

Charles M. Krinsky, M.D.
Psychiatrist, Private
Practice; Connecticut
State Medical Society

William Lavery, Attorney
Public Member

Mrs. James J. Lawlor
Consultant, Central
Naugatuck Valley Regional
Planning Agency; CHP B
Agency Representative

*Douglas Lloyd, M.D.
Commissioner, Connecticut
State Department of Health

Harald Loe, D.D.S., Dean
University of Connecticut
School of Dental Medicine

Edward W. Maher, Commissioner
Connecticut State Department
of Welfare

*Robert U. Massey, M.D.
Dean, University of Connecticut School of Medicine

Robert W. McCollum, M.D.
Chairman, Department of
Epidemiology and Public Health,
Yale University School of
Medicine

Edwin R. Meiss
Chairman, Conference of
Health Organizations

John Nicklis
Retired Industrialist;
Public Member

William F. Nyhan
Industrial Engineer;
CHP B Agency Representative

*Mrs. Robert Ogden
Housewife;
Public Member

David Parke, M.D.
Meriden-Wallingford Hospital;
Chairman, Conference of
Hospital Medical Staffs

Louis Rabineau, Ph.D.
Chancellor, Connecticut
Commission for Higher
Education

W. James Rice, Commissioner
Connecticut State Department
of Community Affairs

*Perry R. Roehm, Vice
President, The Barden
Corporation; Public Member

Mrs. Anna Schulerud, Chair-
woman, Housatonic Valley/
Putnam Community Health
Planning Agency; CHP B
Agency Representative

Ernest A. Shepherd
Commissioner, Connecticut
State Department of
Mental Health

Herbert Steinman, D.D.S.
General Dentistry; Con-
necticut State Dental
Association

Leopold M. Trifari, M.D.
Past President, Connecticut
Hospital Planning Commission

Willis Underwood, Director
West Haven Veterans
Administration Hospital

Guy W. Van Syckle, M.D.
Radiologist, Private
Practice; Connecticut
State Medical Society

Ruth Whittemore, M.D.
Pediatrician; Con-
necticut Heart Association

James D. Whitten, Chairman
Commission on Hospital
and Health Care; CHP A
Agency Representative

Clarence T. Williams
Businessman; CHP B
Agency Representative

Charles B. Womer, Director
Yale-New Haven Hospital

OFFICERS AND OTHER DIRECTORS OF NEW HAVEN HEALTH CARE, INC.

Bruce Arneill, Chairman*
United Way of Greater New Haven, Inc.

Courtland S. Wilson, Vice-Chairman*
Black Coalition

Roger Everson*
Citywide Neighborhood Board of Directors

Alan Goodman, M.D., Recording Secretary*
New Haven City Medical Association

David Sheehan, Secretary*
Connecticut Blue Cross

Donna Diers*
Yale Schools of Medicine and Nursing

Herbert Paris*
Area Hospitals

Carole Hart*
Town of Woodbridge

Cornell Scott
Health Maintenance Organizations

Orvan Hess, M.D.
New Haven County Medical Association

Edward DeLouise
Health Departments

*Denotes Executive Committee Member

Jane Keeler
Visiting Nurse Association of New Haven

Vacant
South Central Connecticut Regional Mental Health Planning Council, Inc.

Paul Taylor, O.D.
Connecticut Optometric Society

Andrew Anastasio, D.P.M.
Connecticut Podiatry Association

Howard Bierkan
Connecticut Medical Service

John Harder
State Welfare Department

Milton Stitzel
Social Security Administration*

Clayton Martindale
Black Coalition

Leona Brandon
Citywide Neighborhood Board of Directors

Gilbert Rochon, III
Citywide Neighborhood Board of Directors

Herman Soto
Citywide Neighborhood Board of Directors

William Fers
Town of Orange

Barry Hawkins
Town of West Haven

Vacant
Town of North Haven

*Ex-officio

Mark DeFrancesco
Town of East Haven

F.D. Grave
Greater New Haven Chamber of Commerce

Vacant
Greater New Haven Central Labor Council

Roslyn U. Fishman
South Central Connecticut Comprehensive Health Planning, Inc. #

Edward Morrissey
Connecticut Regional Medical Program #

Betty Lujan
Mayor's Office, City of New Haven

Hon. Anthony Ciarlone
State Legislator

Hon. Lucien DiMeo
Regional Council of Elected Officials

Vacant
State Government Official

Ex-officio

SCC | SOUTH CENTRAL CONNECTICUT COMPREHENSIVE HEALTH PLANNING, INC.
CHP

TRANSITION COMMITTEE - NOVEMBER 1975

me	Occupation	Category Represented
san Addiss	Health Director LNV Public Health Dept.	Public Health
arles Allen	Director, United Newhallville Organization	Inner-city New Haven
ra Arterburn	Executive Secretary Conn. Assoc. of Extended Care Facilities	Conn. Assoc. Extended Care Facilities
E CHAIRMAN yer Baldwin	Attorney Baldwin & Lieberman	GNH component
R hard Benfer	Asst. Administrator Hospital of St. Raphael	Community Hospital
garet Benton, R.N. (alt: Marilyn Beach)	Exec. Director Regional VNA	Home Health Agencies
G rge Bonner, M.D.	Physician	PSRO
raine Borrack		Homemakers
R rt Carter	Aetna Life Insurance	HiCHAP AREA II
Jo . Daley	Director North Haven Community Services	Chairman - Drug Council
Ed rd DeLouise	Director New Haven Health Dept.	Health Depts.
Dr Isadore Falk	Executive Director Community Health Care Center Plan	HMOs in AREA II
ar la Fink	Citizen	Milford-Orange Component
ol nd French	Minister Seymour	Chairman Region II Regiona Mental Health Board
rv Hess, M.D.	Physician	New Haven County Medical Society

ne	Occupation	Area	Category Represented
chard M. Grave	Manufacturer FD Grave & Son		Business & Industry
nklin Harris	Retired President Kerite Co.		New Haven Foundation
E-CHAIRMAN frey Heusser	Writer		Chairperson LNV Community Council & United Fund
tt Isacson, D.C.	Chiropractor		Chiropractors
oy Jones	Development Administrator City of New Haven		Mayor, New Haven
is Kaplan	Assistant Dean Yale University School of Medicine		Yale Medical Center
a LoPresti	First Selectman Town of Seymour		Vice-Chairman Valley Council of Governments.
RMAN us R. McCraven	Director, Environmental Engineering United Illuminating		GNH Component
e Morris	State Representative		Black Elected Officials - Inner City New Haven
iam Nyhan nge)	Management Engineer Armstrong Rubber		Business & Industr Milford-Orange Component
ming Norcott	Executive Director Center for Advocacy Research & Planning		Inner-City New Haven
O'Rourke			Alcohol Councils
d Pellegrino, M.D.	Chairman of Board Yale-New Haven Medical Center		Yale Medical Cente
ie Perry	Director Ansonia Community Action		Black Community in LNV
Propper			South Central Regional Mental Health Planning Council

Name	Occupation	Category Represented
Marcia Richardson	Yale University Dept. of Epidemiology & Public Health	Regional Plannin Agency of SCC Rep. to SCC/CHP Board
Lawrence Shobe	Executive Director TEAM	TEAM, CPI & Meriden ACC (CAP agencies)
Marjory Schmitt	First Selectwoman Town of Guilford	Public Elected Officials
ave Sheehan	Vice President Conn. Blue Cross	Payors in Area I
era Serio	Vista Volunteer	Italian Communit
ndrés Vega (alt: J. Gonzales)	Liaison Coordinator JUNTA	JUNTA
mund Worfolk	Retired	Milford-Orange component
. Jeffrey Yale	Podiatrist	Podiatrists

SERVERS

ward Morrissey	Director Conn. Regional Medical Program
Thompson	Urban League
n Wadley	Alderman - New Haven
hael Weber, D.D.S.	State Health Dept.
Weirick	Conn. Society of Medical Technology
Williams	Family Planning Consortium

RE ESENTATIVES TO BE APPOINTED

Co . Coalition of Independent Health Professions (Allied)
Co ecticut Dental Society
Ce ral Labor Council of GNH

ST

Ros n U. Fishman	Executive Director SCC/CHP 345 Whitney Ave. New Haven	M. David Vail	Executive Directo LNV Community Cou 75 LIberty St. Ansonia, CT.

VI 11/25/75

* Nominee to HSA Governing Bod

TRANSITION COMMITTEE - Addendum, December 1975.

Name	Representing	Consumer or Pro
Bruce Arneil	New Haven Health Care	P
Marilyn Beach	Connecticut Nurses Assoc.	P
Howard Bierkan	Conn. Medical Service	P
Roger Clayman	Conn. State Labor Council	
Jerome Czech	Conn. Society for Clinical Social Workers	P
Anthony DeLuca	Griffin Hospital	P
Donna Diers	Yale School of Nursing	P
Jean Grinold	Wallingford	C
Sandra Holley	Conn. Coalition of Independent Health Professions	P
Jane Keeler	Home Health & Nursing Svcs.	P
Muriel LeMay	Wallingford Visiting Nurses Association	P
Julie Marshall	United Way of GNH	P
M.D. Mermelstein	Conn. Psychologists Assoc.	P
Mr. J. McIntyre	Meriden-Wallingford Hosp.	P
Tom Murphey	West Haven	
Kermit Nash	Black Health Professionals	P
George Plaskowitz	Milford Hospital	P
Carl Puleo	Rehabilitation Centers	P
Ray Puslys	West Haven - Environmental Health	P
Cornell Scott	Hill Health Center	P
J. Siebert	Milford	C
Courtland Wilson	Black Coalition NHHC Board	P

New Haven Health Care, Inc. Transition Committee

Courtland S. Wilson, Chairman	P
Donna Diers, Dean Yale School of Nursing	P
Cornell Scott, Director Hill Health Center	P
Alan Goodman, M.D., New Haven City Medical Assn.	P
Jane Keller, Executive Director VNA	P
Howard Bierkan, Vice-president, CMS	P
Carole Hart, Woodbridge	C
Herbert Paris, Assoc. Director, Yale-New Haven Hosp.	P
Gilbert Rochon, D.D.U., Representative, Neighborhood Corporation	P
Barry Hawkins, Attorney, West Haven	C
Lucien DiMeo, Mayor, Hamden, RCEOSC	C
David Sheehan, Vice-president, Connecticut Blue Cross	P
Mark DeFrancesco, Connecticut Savings Bank, East Haven	C

P = provider

C - consumer

APPENDIX D: GOVERNOR'S SYSTEM

PART I: TRANSITION STAFF MEMORANDUM AND HEALTH SUBCOMMITTEE

PART II: CRMP AD HOC COMMITTEE

Feb. [illegible]

MEMORANDUM

TO: Governor-elect - E.T. Grasso

FROM: D. Rezendes

RE: Transition of Government

CC: G.C.;N.R.C.

As part of a comprehensive strategy to facilitate the transition to the new State administration and to provide the Governor-elect with critical information for early decision-making, it is proposed: that briefing books on the major departments and agencies be prepared for use by the Governor-elect and her ultimate commissioner appointees.

1. Departmental and Agency Briefing Books

The briefing books would contain comparable information on each of the agencies along the following lines:

(a) Statutory authorities
(b) Basic program
(c) Level of funding
(d) Level of staffing
(e) Organizational chart
(f) Key personnel now on board
(g) Existing vacancies
(h) Civil Service coverage
(i) Major policy issues now confronting the department or agency
(j) Evaluation of existing programs (studies already completed, outside critics, etc.)
(k) Suggestions on programs of low effectiveness which may be eliminated and new programs which may be launched by the Governor
(l) Key interdepartmental issues
(m) Alternative solutions and programs for issues raised

Using this general outline for the briefing books, and in accordance with the proposed organization structure and preliminary work program hereinafter specified, a team of attorneys, experienced public administrators, and others are being recruited to one or more particular departments or agencies to complete their briefing book within 45 days.

It is also proposed that the group will be known as the Governor's transition staff working under the over-all direction of Dennis Rezendes and his chief of staff, Clement Kerley. Mr. Kerley is Manager Manpower Committee at Pitney-Bowes located in Stamford.

The work to be performed is staff work. This is not a committee or commission. Therefore, no report or recommendation is to be made for public release or consumption. The rationale here is simply that the Governor-elect on first assuming office can use a much larger staff in the f 45 days of her administration to assist her in quickly getting hold of the reins of government.

Much of the work to be performed by the transition staff will continue to be performed throughout the Governor's term of office. Obviously sound administrative practices dictates that review and evaluation of programs is an on-going and continuing function.

Principally because of the magnitude of the tasks to be performed, the limitations imposed by time and available resources and other considerations which are apparent and need not be stated here not all of the departments and agencies need to be included in this effort.

It is proposed that all regualtory agencies be excluded and that all Departments headed by an elected official also be excluded. Obviously where an activity or program in any of these agencies and departments has a bearing upon a program or activity being reviewed it must be considered; but, only in the context of the program being reviewed.

Similarly, budget analyses is not to be part of this work. However, where budgetary data or other budgetary consideration may be essential to a proper review it shall be accomplished. Hence, the need for the interim staff group to have clear and open communication with George Conkling as he goes about performing his budgetary functions and vice-versa.

The proposed organization chart clearly sets forth how the staff is to be organized and the areas of responsibility.

The various departments and agencies have been grouped below in three orders of priority. Those listed in the first order of priority are those departments and agencies that the interim staff is absolutely committed to complete within the specified time. Those grouped in the second order of priority are those agencies and departments that the interim staff will give "best effort" to complete within the 45 days time frame. Those listed in the third priority groups in all likelihood cannot be reviewed within the time frame of 45 days.

First Priority Departments & Agencies

Department of Children, Youth Services
Department of Community Affairs
Department of Environmental Protection
State Department of Health
Labor Department

First Priority Departments & Agencies (con't.)

Department of Mental Health
Department of Transportation
State Welfare Department
Department of Commerce
Connecticut Housing Finance Authority

Second Priority Department & Agencies

Consumer Protection
Connecticut Planning - Committee on Criminal Administrations
Department of Motor Vehicles
State Police
Public Works
Department of Personnel

Third Priority Departments & Agencies

State Commission on the Arts
Banking Department
Compensation Commission
Department of Correction
Corrective and Associated Agencies
Development Planning and Research
Department of Finance and Control
Connecticut Historical Commission
Commission on Human Rights and Opportunities
Council on Human Services
Insurance Department
Library
Military Department
Tax Department
Veterans

Those departments and agencies listed as first priority will be grouped into six major categories.

① Human Services - Welfare, Children and Youth Services, Mental Health, Health, Aging
2. Economic Development - Labor, Commerce
3. Education - all aspects of education
4. Community Development - Department of Community affairs and Connecticut Housing Finance Authority
5. Transportation - Department of Transportation
6. Natural Resources - Department of Environmental Protection, and Energy

A team headed by a competent person consisting of at least six professional staff persons will perform the review and evaluation. Attached to this memo is a preliminary list of team members and sources for obtaining other team members.

The timetable is to have a meeting with the chairman on December 27th in Hartford or orientate them and seek their input in the design of the work program. There will then be a general meeting on the 30th of Decemver with the entire interim transition staff.

The proposed starting date of actual work is January 2nd with a completion date of February 10th.

The above described program is a "first cut" and was accomplished at some distance. Obviously it can, and in all likelihood will, be modified to reflect the administration's priority needs.

No such undertaking can be accomplished without the cooperation of the state agencies. Therefore, the tone and the thust of the work will be that of being helpful and support. Inaddition, the interim staff is the Governor's staff and, therefore, has the Governor's stamp of approval. The combination of these two ingredients should help immeasurably in d-veloping a positive attitude and approach rather than a negative one which can only be counter-productive at best.

With respect to the matters of publicity, a single straight forward statement should be issued soon. It should state the prupose of the interim transition staff, who are its participants and the fact that staff work is being performed and no report will be made for the public distribution.

Upon completion of the work the interim transition staff is to be thanked for their voluntary efforts, etc. There are to be no releases, no statement, etc.during the course of the work by the staff.

Space has been secured on Elm Street. Desks and chairs are in place. Phones have been ordered.

In order for us to proceed further in our planning and organizing efforts, we need further input from the administration.

Interim Transition Staff

Members

Clement Kerley - Full time not to exceed 45 days - Pitney Bowes

Peter Libossi - on as needed bases - 45 days Greater Hartford Process

Robert PatrecQlli - assigned to Community Development - Greater Hartford Proce

Sidney Gardner - assigned to Education - Greater Hartford Process

Dan Simpson - Assisgned to Human Service - Greater Hartford Process

Paul Ehrhardt - unassigned - Greater Hartford Process

Fred Hyde - Human Services - Connecticut Hospital Association

Edward Morrissey - Human Services - Connecticut Regional Medical Program

Sid Simpson - Education - Greater Hartford Process

Louis Kaplan - Human Services - Assist Dean - Yale Medical School

The above have given a firm pledge to serve. The following are potential interim transition staff members.

MD Morton Colman - Human Services Chairman - UCONN - DEAN - SCHOOL OF SOCIAL WORK

James Sandler - Economic Development Chairman - attorney based in Hartford.

John Keever - Economic Development - Greater Hartford Chamber of Commerce

John Allison - Education - Capital Region Education Council

Louis Friedman - Education - Head master - Westledge School, Simsbury

VMD Morton Tenzer - Community Development UConn Professor

Ernest Osborne - Community Development - Ececutive Director, The Sachem Fund

Wilbur Smith - Department of Transportation - Wilbur Smith Associates

John Cavallaro - Transportation - Directs New Haven Parking and Traffic Department

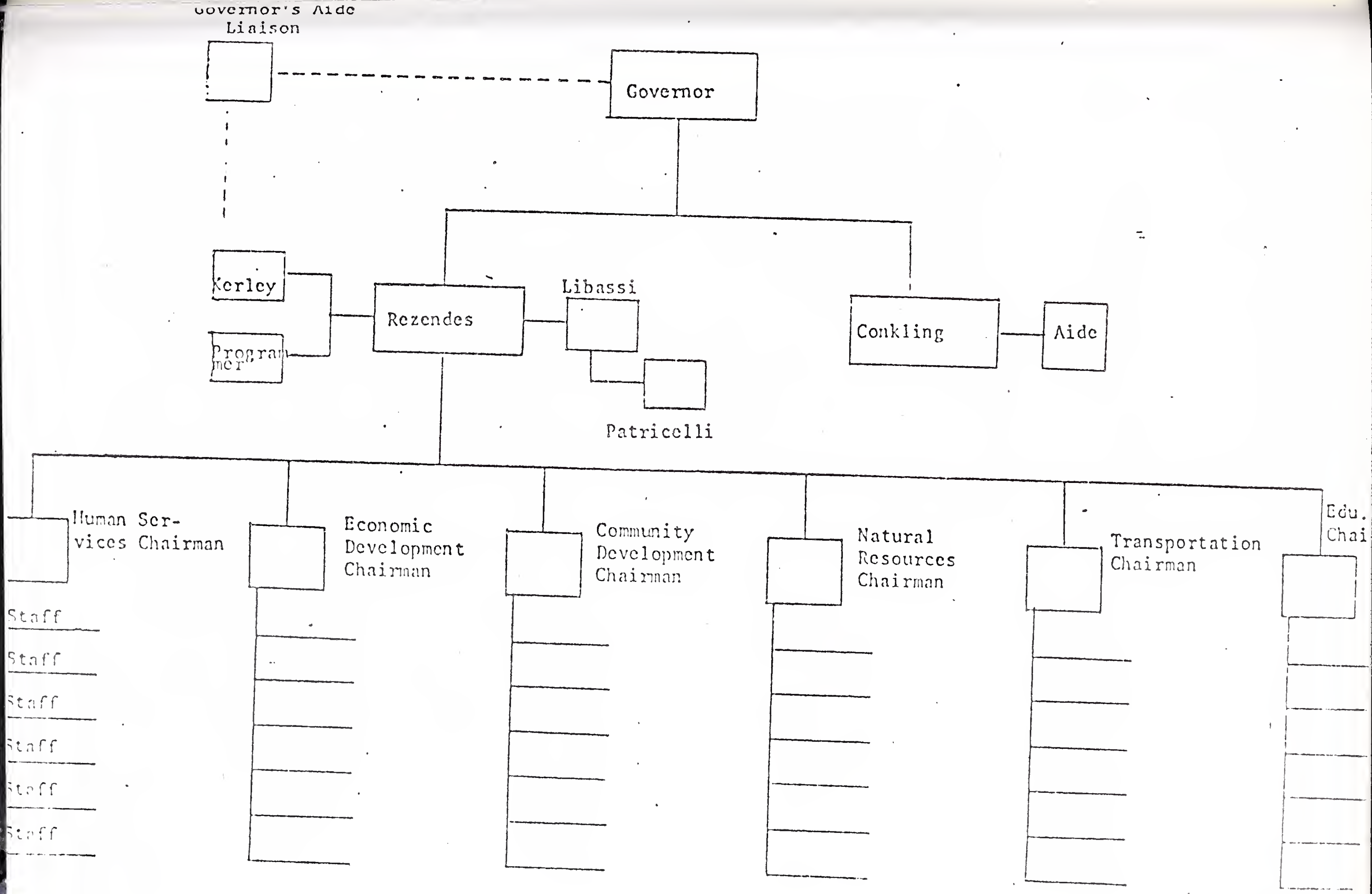
Harvey Moser - Natural Resources - Connecticut General Life Insurance

VMD Peter Kelly - Natural Resources Chairman - Hartford Attorney

The following are some potential sources for staff recruiting:

Yale University
UConn
Yale University Law Students
UConn law students
"Big Eight" accounting firms
General Electric
Olin
Hartford based insurance companies
Chambers of Commerce

What needs to be identified by the administration is what organizations, firms, institutions or individuals should not be approached because of real or potential conflicts of interest or for other reasons.


Governor's Aide
Liaison
Governor
Kerley
Programmer
Rezendes
Libassi
Patricelli
Conkling
Aide
Human Services Chairman
Staff
Staff
Staff
Staff
Staff
Staff
Economic Development Chairman
Community Development Chairman
Natural Resources Chairman
Transportation Chairman
Edu. Chai

Members of the Volunteer Transition Staff
Human Services Group
Health Committee

Co-chairmen

Fred Hyde, M.D., Vice-President for External Affairs, Connecticut Hospital Association
Cornell Scott, Director, Hill Health Center
Susan Addiss, Director, Valley Health Department
John M. Danielson, Executive Director, Capital Area Health Consortium, Inc.
John R. Gaintner, Associate Dean, University of Connecticut Health Center
Lou Hochheiser, Assistant Professor of Pediatrics, University of Connecticut Health Center
Louis J. Kaplan, Assistant Dean, Yale Medical School
Selma L. Markowitz, Executive Director, Connecticut Institute for Health Manpower Research

Staff

Priscilla Blassingale, Associate Director of Planning, United Way, New Haven
Ed Bradley, Associate Program Coordinator, CRMP
Gary Sax, Yale Medical School

AD HOC STATE AND REGIONAL HEALTH RESOURCE COMMITTEE OF THE CONNECTICUT REGIONAL MEDICAL PROGRAM
(Proposed)

Chairman
John W. Patterson, M.D., Vice-President for Health Affairs, University of Connecticut

Morton Coleman, M.D., School of Social Work, University of Connecticut
Milton Markowitz, M.D., Chairman, Department of Pediatrics, University of Connecticut
John D. Thompson, Professor of Public Health, Yale University
Boris Astrachan, M.D., Director, Connecticut Mental Health Center, Yale University
Fred Hyde, M.D., Director, Public Affairs, Connecticut Hospital Association
Marcus McCraven, President, South Central CHP Agency
Ralph Pollack, Executive Director, Capitol Region "B" Agency
Carroll Hughes, Former Assistant Commissioner, Department of Environmental Protection
Mrs. Frank Taylor, President, Connecticut Social Welfare Conference
Arthur Rogers, CRMP Advisory Board
Perry Roehm, CRMP Advisory Board
Guy Van Syckle, M.D., CRMP Advisory Board
John Barone, Ph.D., CRMP
John Glasgow, Ph.D., CRMP
Anthony Canzonetti, M.D., Hartford County Medical Society (PSRO Chairman)
James Kenney, M.D., Institute of Medicine

APPENDIX E: DR. ADAMS' SYSTEM

PART I: COLLEAGUE COMMITTEE

PART II: TASK FORCES

ADDENDUM I

Director's Colleague Committee Members

Dr. Greg Belok, a dentist and a post doctoral student in public health systems, has been active in public health at Yale.

Ms. Linda Bourret, Photographer and Owner of Studio 13, was chosen because of her photographic expertise which was used in compiling a pictorial record of the State Health Systems Plan.

Ms. Catherine Havens-Brown, Director, Women's Center, University of Connecticut, has demonstrated a commitment and concern for fulfillment of the need for health care for women.

Dr. Arthur C. Cosmas, Assistant Dean for Student Affairs, University of Connecticut, was chosen on the basis of his administrative skills and his research methodology. He has also worked directly with Dr. Adams in health related sciences for three years.

Dr. Shan Cretin, Assistant Professor of Biostatistics, Harvard University School of Public Health, has an extensive background in systems planning and is knowledgeable about the State of Connecticut, having received her M.P.H. from Yale and having served as a consultant to the University of Connecticut School of Allied Health Professions.

Dr. Evans H. Daniels, Medical Director, Community Health Services, Inc., has extensive experience in community health clinics, including their philosophy and their relation to delivering care to patients.

Dr. Maye H. Grant has diversified experience in child and family health as well as in planning, having been one of the planners for the School of Allied Health Professions at the University of Connecticut.

Dr. William E. Hart, Director of Pediatrics, St. Francis Hospital and a member of the faculty at the University of Connecticut Health Center, has demonstrated concern for health systems delivery in order to extend better and more qualitative care to a broader number of people.

Mrs. Virginia Henderson was chosen because of her pursuits toward her Ph.D. degree and her strong desire to specialize in health administration.

Mrs. Donna Hite, Secretary to the Vice President for Student Affairs and Services, University of Connecticut, was needed for her secretarial skills in order to expedite the work flow necessary for completion of this project.

Dr. Fred Hyde, Vice President, External Affairs, the Connecticut Hospital Association, has a unique background in health. He is closely associated with the hospital network throughout the state and his physician orientation and continued pursuit of a law degree made him a unique and different type of talent necessary for achievement of the plan.

Ms. Rosemary Johnson, Executive Assistant to the Commissioner of Health, has worked extensively on the subject of hospital service areas and the flow of Connecticut population to hospital facilities. Further, her administrative assistantship to the Commissioner of the State Department of Health ensured access to existing material and documents needed in the planning effort.

Mr. Louis Kaplan, Assistant Dean, Yale School of Medicine, has a rich background in the area of health care in the State of Connecticut. He is well known through his many community involvements in the state as well as in his role at Yale.

Dr. Philip Levine, Associate Dean, Dental Student Affairs, University of Connecticut School of Dental Medicine, was chosen because of his demonstrated work in increasing the number of women as dentists and physicians through the country.

Ms. Beth Lorenzi was chosen on the basis of her extensive research background at Yale University and Oxford, England and her continued excellence in spinal cord research. Her methodological base was compatible with health planning and systems development.

Dr. Russell Martin, Dental Consultant, Aetna Life Insurance Co., has expertise in health administration. His past background and familiarity with competent health planning at A and B agency levels and his committed concerns for a more refined health care delivery system were relevant to the planning effort.

Mr. Marvin O'Rear, Assistant Hospital Director, Newington VA Hospital, was chosen because of his administrative capabilities and differential experience in the nation-wide VA hospital system. His competencies in hospital administration helped diversify the group.

Mr. Wayne S. Rawlins, University of Connecticut student, has a keen interest in a health career and in the quantitative and qualitative factors relating to health care systems.

Mr. Cornell Scott, Executive Director, Hill Health Center, has an extensive background in health education and administration as well as administrative experience with the premier neighborhood health center in Connecticut.

Mr. Otto Strobino was chosen because of his expertise in rehabilitation and administration both at the institutional and home care levels.

Miss Ann Valenski, Financial Coordinator, School of Allied Health Professions, University of Connecticut was chosen because of her second year student status as a health care administrator and her fiscal background.

Ms. Sharon Weiss, University of Connecticut Student, was chosen because of her journalism background and the new input she would offer.

Mr. Courtland Seymour Wilson, Coordinator, Minority Recruitment Program, Yale-New Haven Medical Center, has years of experience in community organization as well as institutional relationships and professional administrative role responsibilities at the Yale School of Medicine and the Department of Epidemiology and Public Health.

Dr. Jessica Wolf, Mental Health Planner, was chosen because of her administrative background and her direct inter-relationships and involvement in the "state of the arts" in mental health.

ADDENDUM III

TASK FORCES

Aging

Comprehensive Health Planning

Convalescent and Rest Homes

Dental Health

Drug and Alcohol Abuse

EHSDS

Federal Legislation

General Hospitals

Insurance Industry

Legislative

Medical Health Care Delivery

Mental Health

Neighborhood Health Centers

Regional Medical Program

State Agencies

University of Connecticut Health Center

Yale-New Haven Medical Center

APPENDIX F: MAPS

MAPS

Map 1 is a map of Connecticut

Maps 2-5 are the pre-existing areas which were taken into account when preparing Map 6.

Map 6 indicates the hospital service areas of the state health department developed in 1967.

Map 7 shows Connecticut towns and counties.

Map 8 shows Connecticut SMSAs.

Map 9 shows the CHP regions of Connecticut as developed from the pre-existing hospital service areas.

Map 10 shows the Connecticut RPAs.

Map 11 is the five Council of Human Services areas.

Map 12 is the Connecticut four PSRO regions.

Map 13 is the NHHC proposal for the HSAs.

Map 14 is the CRMP proposal for HSAs.

Map 15 is the fall-back position recommended by CHP as a second choice in the event that Governor Grasso decided not to seek waivers.

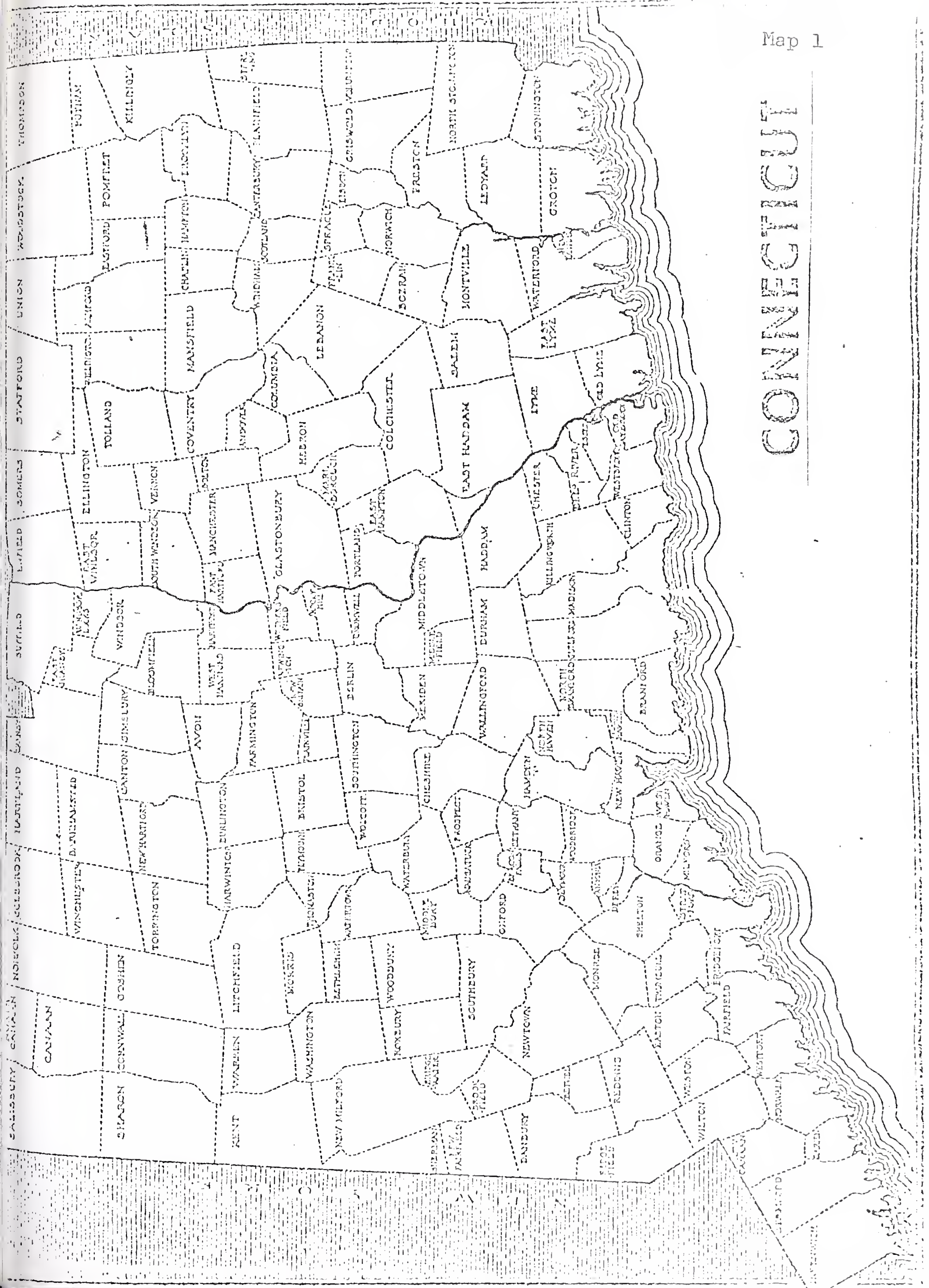
Map 16 is the first choice of the majority of CHP agencies for the HSA areas.

Map 17 is the first HSA designation plan submitted by Governor Grasso.

Map 18 is the final HSA designation for Connecticut following public outcry for waivers to modify the first plan.

Maps 19-24 are comparisons between the pre-existing divisions of Connecticut and the final HSA designation demonstrating maintenance of CHP, RPA, and to a lesser extent, CHS lines.

Map 1


CONNECTICUT
THOMPSON
PUTNAM
KILLINGLY
WOODSTOCK
POMFRET
EASTFORD
UNION
ASHFORD
STAFFORD
WILLINGTON
TOLLAND
MANSFIELD
CHAPLIN
HAMPTON
BROOKLYN
CANTERBURY
SCOTLAND
WINDHAM
PLAINFIELD
STERLING
GRISWOLD
VOLUNTOWN
NORTH STONINGTON
STONINGTON
PRESTON
LEDYARD
GROTON
LISBON
SPRAGUE
NORWICH
FRANKLIN
BOZRAH
MONTVILLE
WATERFORD
NEW LONDON
EAST LYME
SALEM
LEBANON
COLUMBIA
COVENTRY
ANDOVER
HEBRON
COLCHESTER
EAST HADDAM
LYME
OLD LYME
OLD SAYBROOK
ESSEX
DEEP RIVER
CHESTER
WESTBROOK
CLINTON
KILLINGWORTH
HADDAM
EAST HAMPTON
MARLBOROUGH
PORTLAND
GLASTONBURY
BOLTON
VERNON
MANCHESTER
ELLINGTON
SOMERS
ENFIELD
EAST WINDSOR
SOUTH WINDSOR
EAST HARTFORD
WINDSOR LOCKS
WINDSOR
SUFFIELD
EAST GRANBY
GRANBY
BLOOMFIELD
HARTFORD
WEST HARTFORD
WETHERSFIELD
ROCKY HILL
NEWINGTON
CROMWELL
MIDDLETOWN
MIDDLEFIELD
DURHAM
MADISON
GUILFORD
NORTH BRANFORD
BRANFORD
EAST HAVEN
NORTH HAVEN
NEW HAVEN
WEST HAVEN
HAMDEN
WALLINGFORD
MERIDEN
BERLIN
NEW BRITAIN
PLAINVILLE
SOUTHINGTON
FARMINGTON
AVON
SIMSBURY
CANTON
HARTLAND
BARKHAMSTED
NEW HARTFORD
BURLINGTON
BRISTOL
WOLCOTT
CHESHIRE
PROSPECT
BETHANY
WOODBRIDGE
ORANGE
MILFORD
NAUGATUCK
BEACON FALLS
SEYMOUR
ANSONIA
DERBY
SHELTON
STRATFORD
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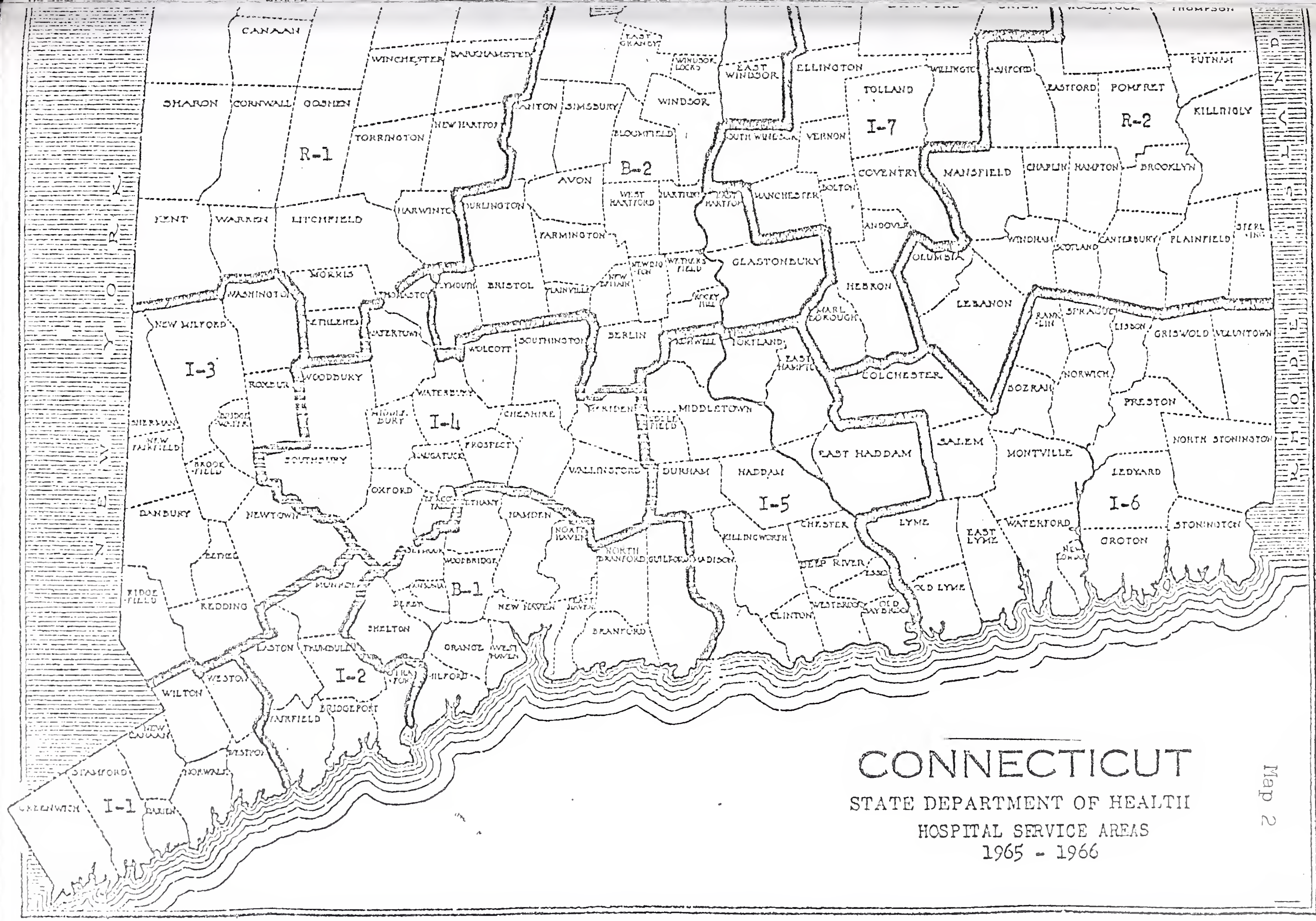
STAMFORD
GREENWICH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FAIRFIELD
NEW CANAAN
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STAMFORD
NORWALK
GREENWICH
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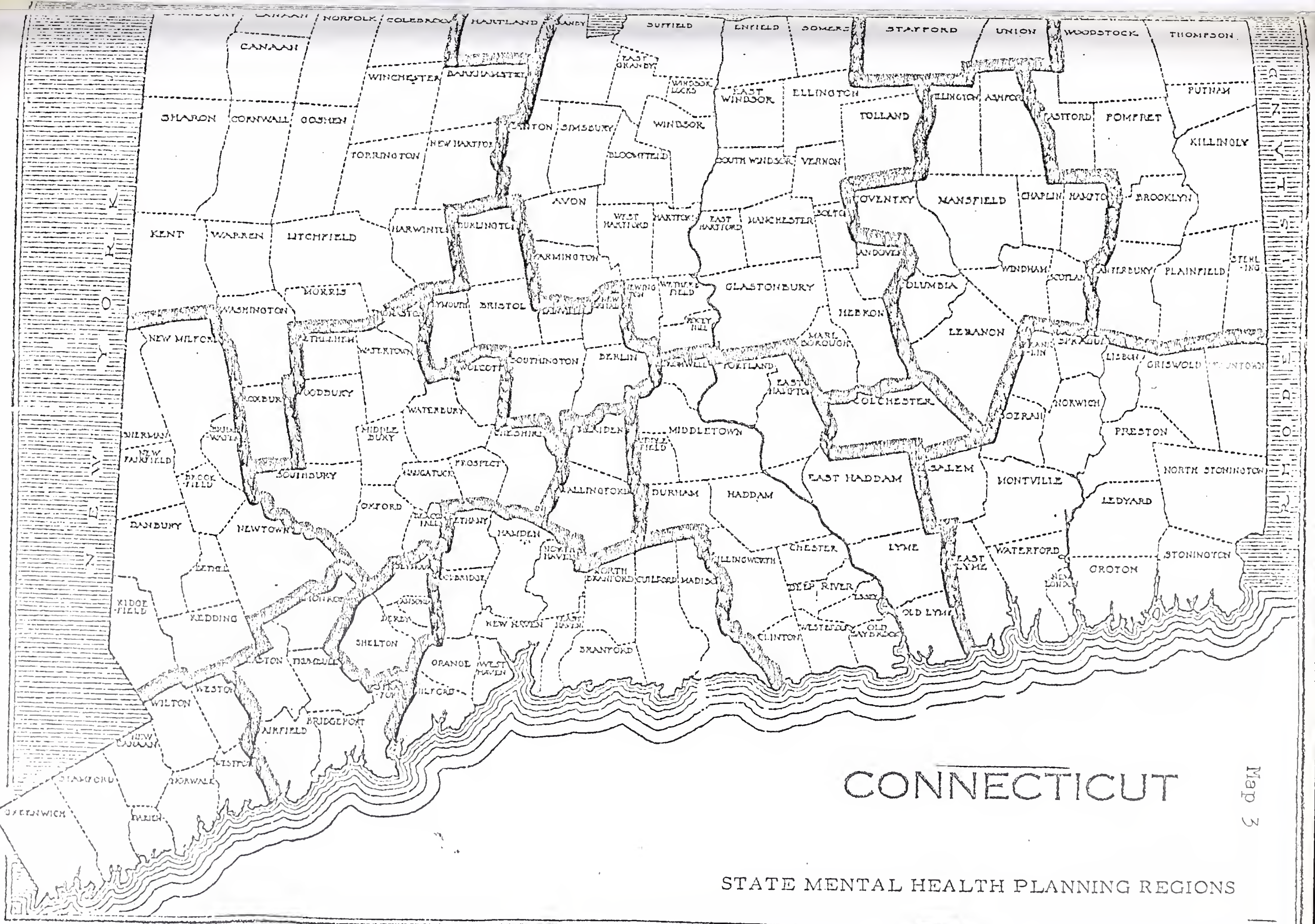
Map 2

CONNECTICUT

STATE DEPARTMENT OF HEALTH
HOSPITAL SERVICE AREAS
1965 - 1966

Form O-L 43 (6-63) 1M

Map 3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BOZRAH
PRESTON
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SOUTHBURY
NAUGATUCK
PROSPECT
WALLINGFORD
DURHAM
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MONTVILLE
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LEDYARD
DANBURY
OXFORD
NEWTOWN
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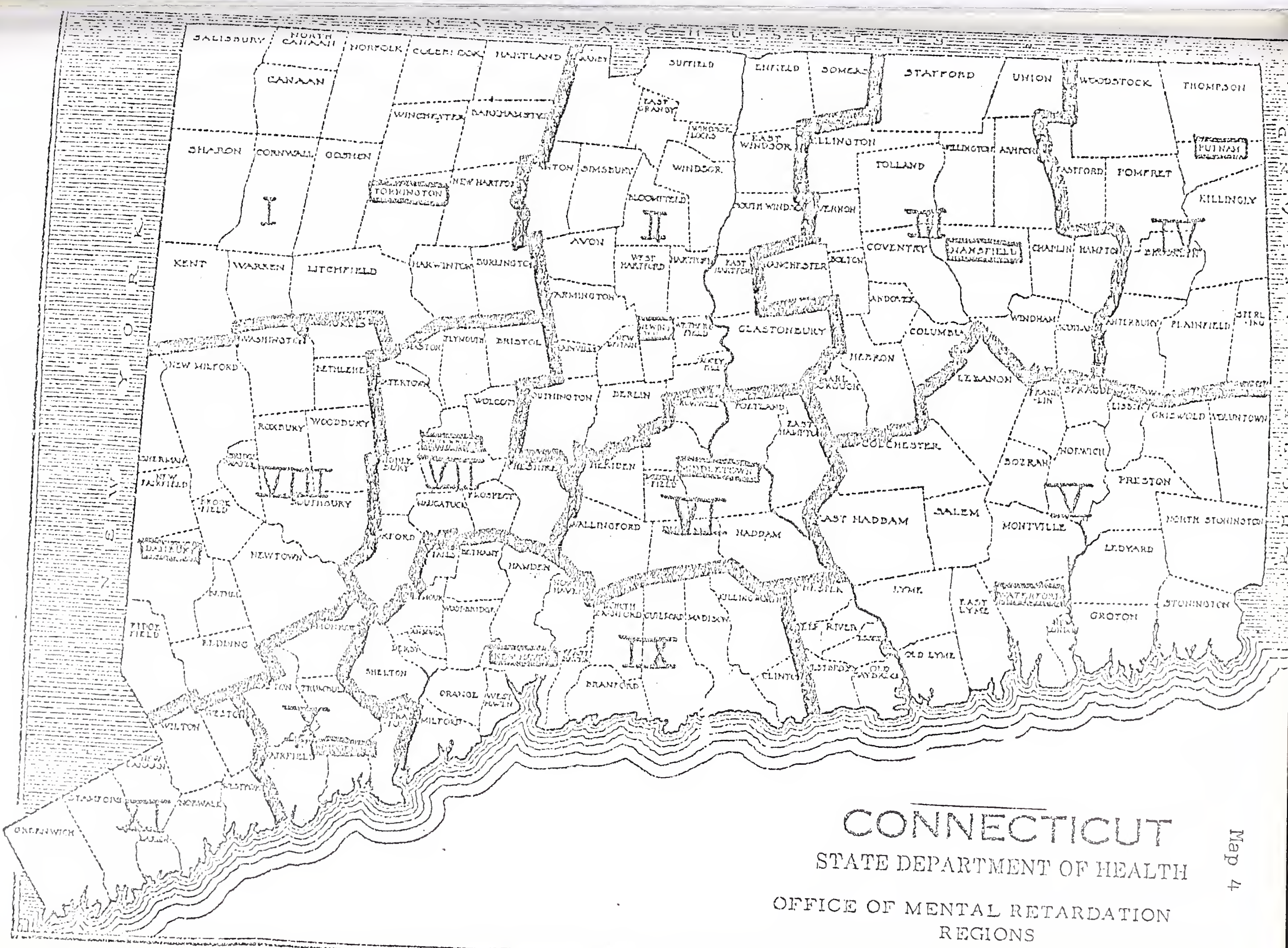
CLINTON
WESTBROOK
OLD SAYBROOK
ORANGE
WEST HAVEN
TRUMBULL
WESTON
WILTON
FAIRFIELD
BRIDGEPORT
NEW CANAAN
WESTPORT
NORWALK
STAMFORD
DARIEN
GREENWICH
NEW YORK
RHODE ISLAND

CONNECTICUT

STATE MENTAL HEALTH PLANNING REGIONS

Form O.A. 43 (6-62).1M

Map 4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STAFFORD
UNION
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WILLINGTON
ASHFORD
PUTNAM
SHARON
CORNWALL
GOSHEN
TORRINGTON
NEW HARTFORD
SIMSBURY
WINDSOR
BLOOMFIELD
SOUTH WINDSOR
VERNON
EASTFORD
POMFRET
KILLINGLY
KENT
WARREN
LITCHFIELD
HARWINTON
BURLINGTON
AVON
WEST HARTFORD
HARTFORD
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MANCHESTER
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CHAPLIN
HAMPTON
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FARMINGTON
ANDOVER
WINDHAM
STERLING
PLAINFIELD
WASHINGTON
PLYMOUTH
BRISTOL
NEW BRITAIN
WETHERSFIELD
GLASTONBURY
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WOODBURY
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BOZRAH
SHERMAN
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CHESHIRE
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MIDDLETOWN
MIDDLEFIELD
PRESTON
BROOKFIELD
NAUGATUCK
PROSPECT
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DERBY
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OLD LYME
SHELTON
ORANGE
WEST HAVEN
BRANFORD
CLINTON
OLD SAYBROOK
TRUMBULL
WESTON
WILTON
MILFORD
FAIRFIELD
NEW CANAAN
STAMFORD
NORWALK
GREENWICH

CONNECTICUT

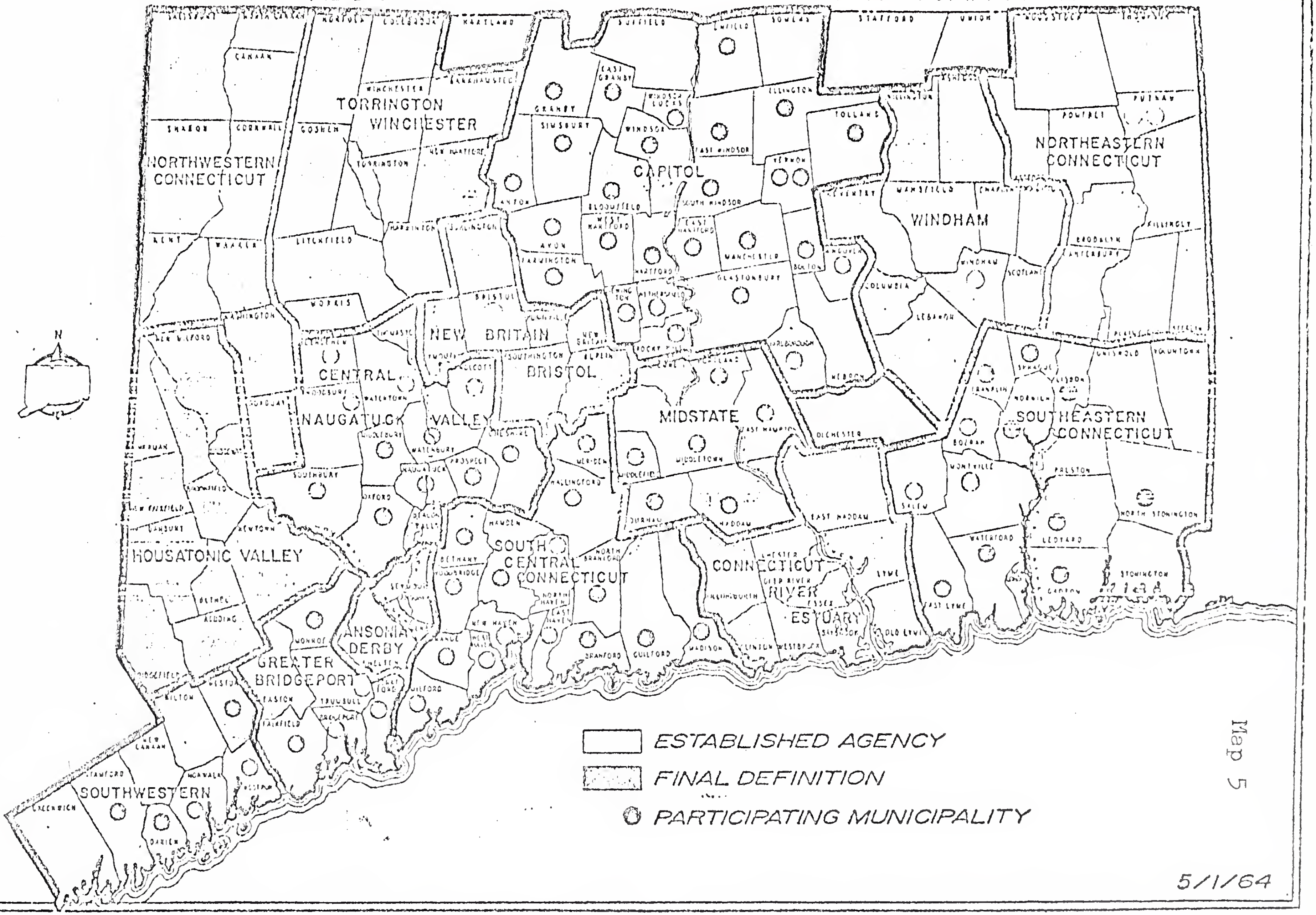
STATE DEPARTMENT OF HEALTH

OFFICE OF MENTAL RETARDATION
REGIONS

Figure 6

PLANNING REGIONS OF CONNECTICUT

AS DEFINED BY CONNECTICUT DEVELOPMENT COMMISSION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TORRINGTON WINCHESTER
CAPITOL
NORTHEASTERN CONNECTICUT
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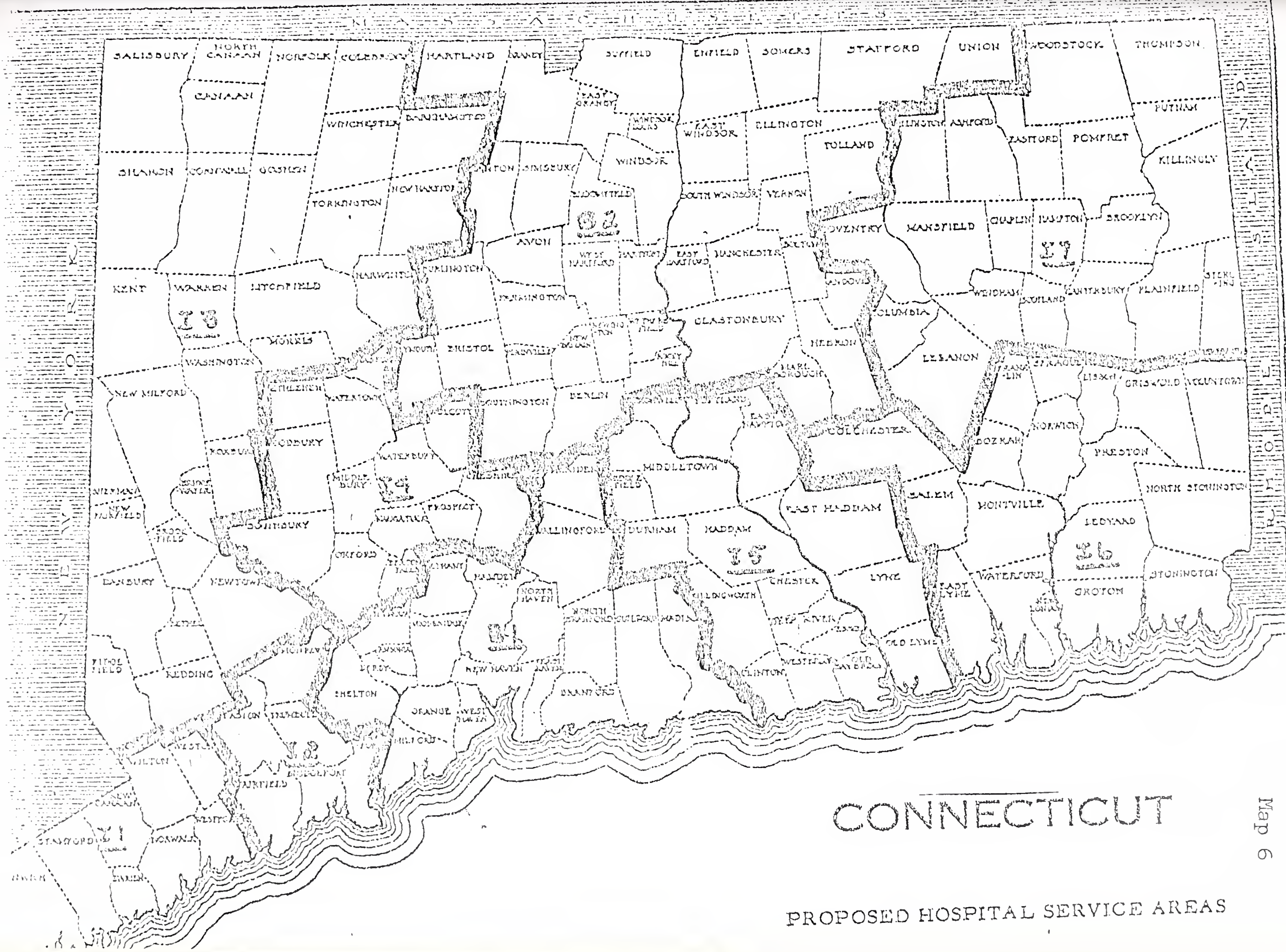
CENTRAL NAUGATUCK VALLEY
MIDSTATE
SOUTHEASTERN CONNECTICUT
HOUSATONIC VALLEY
SOUTH CENTRAL CONNECTICUT
CONNECTICUT RIVER ESTUARY
ANSONIA DERBY
GREATER BRIDGEPORT
SOUTHWESTERN
N
ESTABLISHED AGENCY
FINAL DEFINITION
PARTICIPATING MUNICIPALITY

Map 5

5/1/64

Map 6


MASSACHUSETTS
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GRANBY
SUFFIELD
ENFIELD
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STAFFORD
UNION
WOODSTOCK
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TOLLAND
WILLINGTON
ASHFORD
EASTFORD
POMFRET
PUTNAM
KILLINGLY
SHARON
CORNWALL
GOSHEN
TORRINGTON
NEW HARTFORD
CANTON
SIMSBURY
WINDSOR
BLOOMFIELD
SOUTH WINDSOR
VERNON
COVENTRY
MANSFIELD
CHAPLIN
HAMPTON
BROOKLYN
AVON
WEST HARTFORD
HARTFORD
EAST HARTFORD
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BOLTON
KENT
WARREN
LITCHFIELD
HARWINTON
BURLINGTON
FARMINGTON
GLASTONBURY
ANDOVER
COLUMBIA
WINDHAM
SCOTLAND
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PLAINFIELD
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THOMASTON
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PLAINVILLE
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SHERMAN
NEW FAIRFIELD
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NAUGATUCK
PROSPECT
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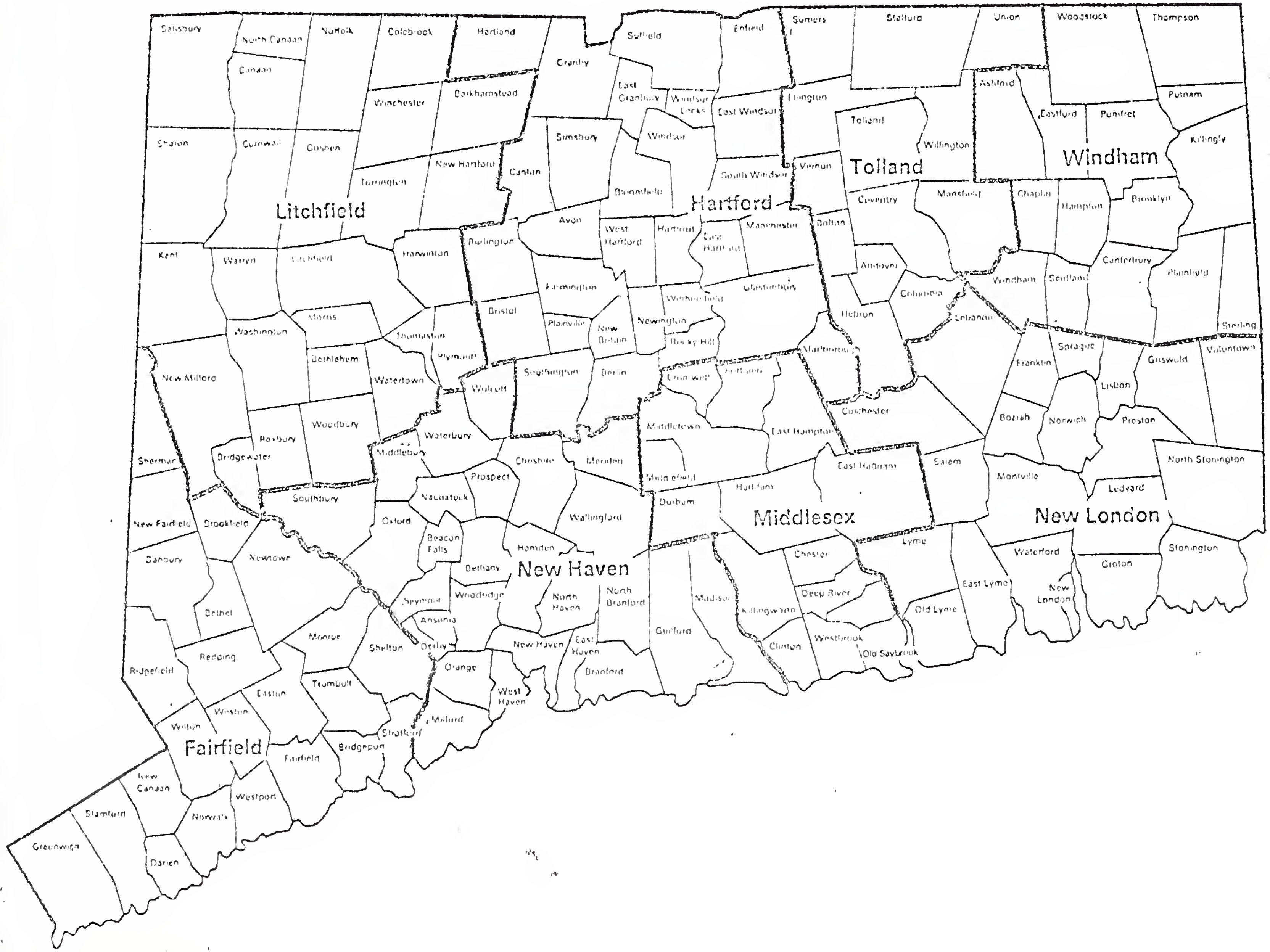
WILTON
WESTON
FAIRFIELD
BRIDGEPORT
NEW CANAAN
WESTPORT
STAMFORD
NORWALK
DARIEN
GREENWICH

CONNECTICUT

PROPOSED HOSPITAL SERVICE AREAS

Towns and Counties of Connecticut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Canaan
Norfolk
Colebrook
Hartland
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Suffield
Enfield
Somers
Stafford
Union
Woodstock
Thompson
Sharon
Cornwall
Goshen
Winchester
Barkhamstead
East Granby
Windsor Locks
East Windsor
Ellington
Tolland
Willington
Ashford
Eastford
Pomfret
Putnam
Killingly
Torrington
New Hartford
Canton
Simsbury
Windsor
Bloomfield
South Windsor
Vernon
Coventry
Mansfield
Chaplin
Hampton
Brooklyn
Kent
Warren
Litchfield
Harwinton
Burlington
Avon
West Hartford
Hartford
East Hartford
Manchester
Bolton
Andover
Columbia
Windham
Scotland
Canterbury
Plainfield
Sterling
Morris
Washington
Thomaston
Bristol
Farmington
Plainville
New Britain
Newington
Wethersfield
Rocky Hill
Glastonbury
Hebron
Lebanon
Sprague
Franklin
Lisbon
Griswold
Voluntown
New Milford
Bethlehem
Watertown
Plymouth
Wolcott
Southington
Berlin
Cromwell
Portland
Marlborough
Colchester
Bozrah
Norwich
Preston
Roxbury
Woodbury
Waterbury
Middlebury
Cheshire
Meriden
Middletown
East Hampton
East Haddam
Salem
Montville
Ledyard
North Stonington
Sherman
Bridgewater
Southbury
Prospect
Naugatuck
Middlefield
Haddam
Durham
Wallingford
New Fairfield
Brookfield
Oxford
Beacon Falls
Hamden
Bethany
Chester
Lyme
Waterford
Groton
Stonington
Danbury
Newtown
Seymour
Woodbridge
North Haven
North Branford
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New London
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Derby
Monroe
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New Haven
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Guilford
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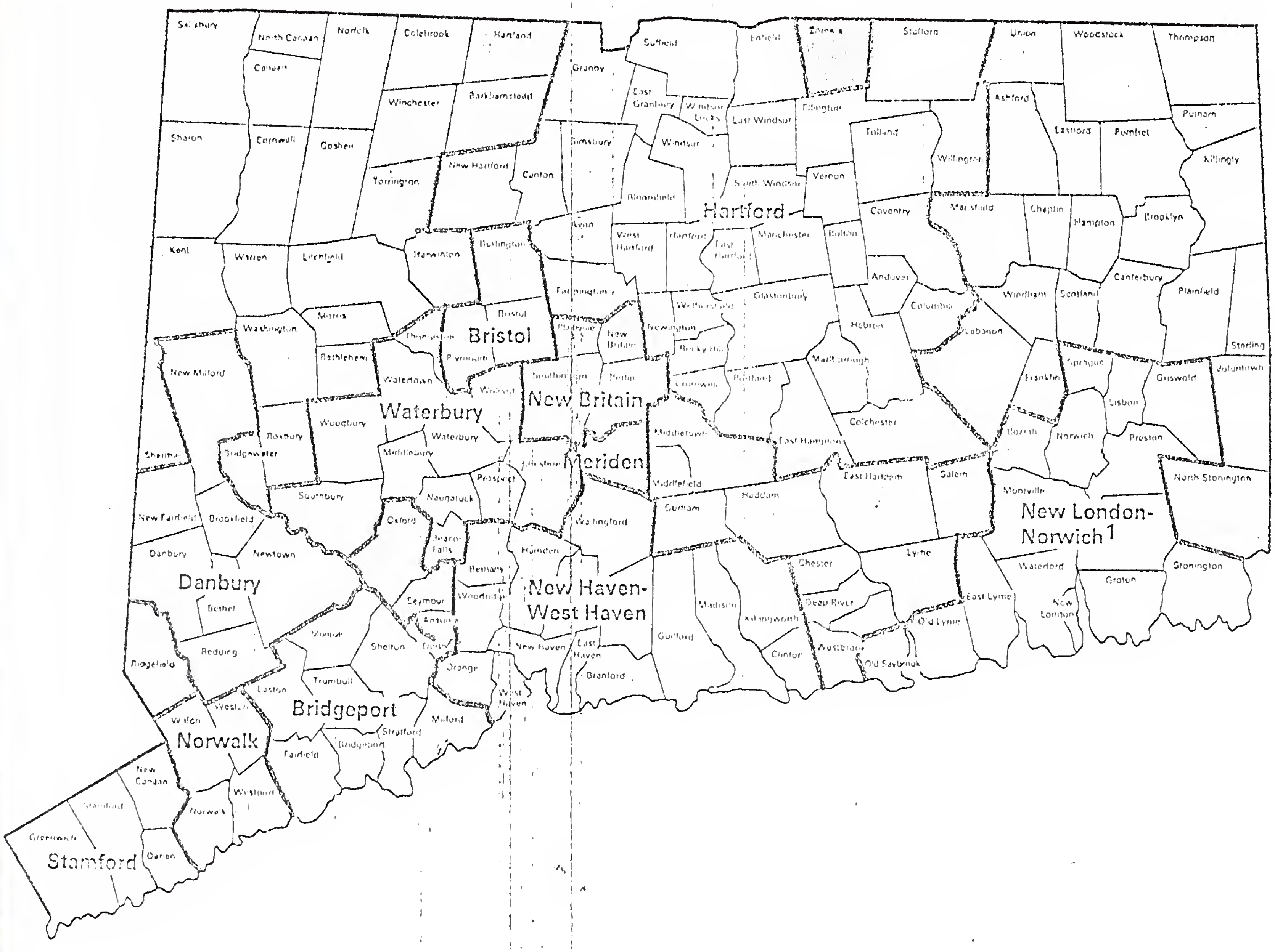
Ridgefield
Redding
Orange
West Haven
Branford
Easton
Trumbull
Weston
Wilton
Milford
Stratford
Bridgeport
Fairfield
New Canaan
Westport
Norwalk
Stamford
Darien
Greenwich

The Project upon which this map is based was performed pursuant to contract no. HSM 110-7 with the Health Services and Mental Health Administration, Department of Health, Educati and Welfare.

New Haven Health Care, Inc.
1303 Chapel Street
New Haven CT 06511
2/75
Approx scale 1 in:15 mi

Map 7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New Britain
Waterbury
Meriden
Danbury
New Haven-
West Haven
New London-
Norwich 1
Bridgeport
Norwalk
Stamford

Standard Metropolitan
Statistical Areas of
Connecticut

Area not in SMSA

Part of Springfield, Mass. SMSA

[1] Includes Hopkinton, Westerly, R.I.

Source: U.S. Dept of Commerce National Bureau of Standards, FIPS Publication 8-1
6/30.74

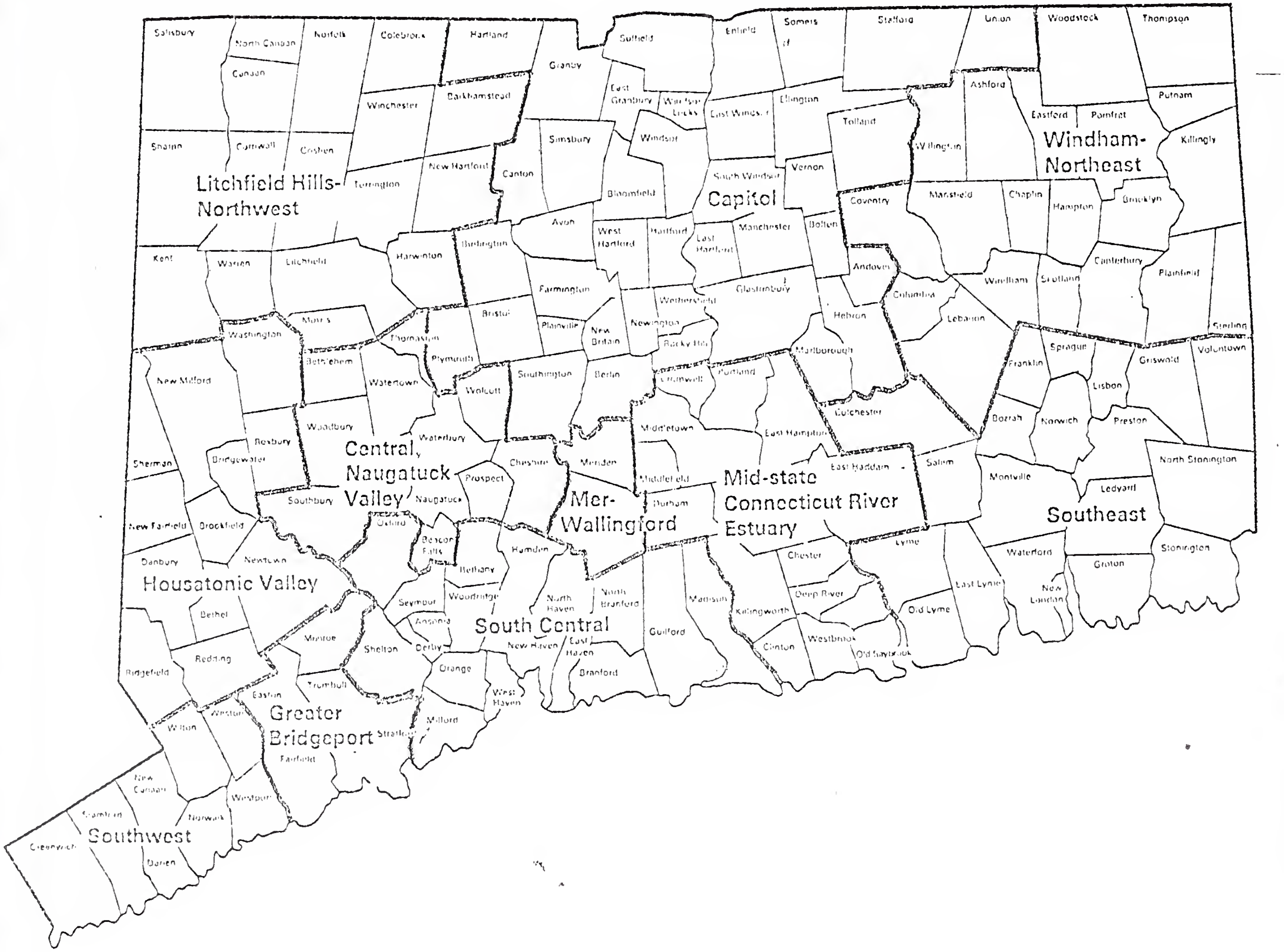
The Project upon which this map is based was performed pursuant to contract no. HSM 110-72-37 with the Health Services and Mental Health Administration, Department of Health, Education and Welfare.

New Haven Health Care, Inc
1303 Chapel Street
New Haven CT 06511
2/75
Approx scale 1 in:15 mi

Map 8

Map 9

Comprehensive Health Planning Regions of Connecticut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Windham-Northeast
Capitol
Central Naugatuck Valley
Mer-Wallingford
Mid-state Connecticut River Estuary
Southeast
Housatonic Valley
South Central
Greater Bridgeport
Southwest
Salisbury
North Canaan
Canaan
Norfolk
Colebrook
Hartland
Granby
Suffield
Enfield
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Stafford
Union
Woodstock
Thompson
Putnam
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Barkhamsted
East Granby
Windsor Locks
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Ellington
Tolland
Willington
Sharon
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Goshen
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New Hartford
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Windsor
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Avon
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East Hartford
Manchester
Bolton
Coventry
Kent
Warren
Litchfield
Harwinton
Burlington
Farmington
Glastonbury
Andover
Columbia
Windham
Scotland
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Plainfield
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Washington
Morris
Thomaston
Bristol
Plainville
New Britain
Newington
Wethersfield
Rocky Hill
Hebron
Lebanon
Sprague
Franklin
Griswold
Voluntown
Lisbon
New Milford
Bethlehem
Watertown
Plymouth
Wolcott
Southington
Berlin
Cromwell
Portland
Marlborough
Colchester
Bozrah
Norwich
Preston
Woodbury
Roxbury
Waterbury
Cheshire
Meriden
Middletown
East Hampton
East Haddam
Salem
Montville
Ledyard
North Stonington
Sherman
Bridgewater
Prospect
Middlefield
Durham
Southbury
Naugatuck
Oxford
Beacon Falls
Bethany
Hamden
New Fairfield
Brookfield
Newtown
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Stonington
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Easton
Trumbull
West Haven
Weston
Wilton
Stratford
Milford
Fairfield
New Canaan
Westport
Stamford
Norwalk
Greenwich
Darien

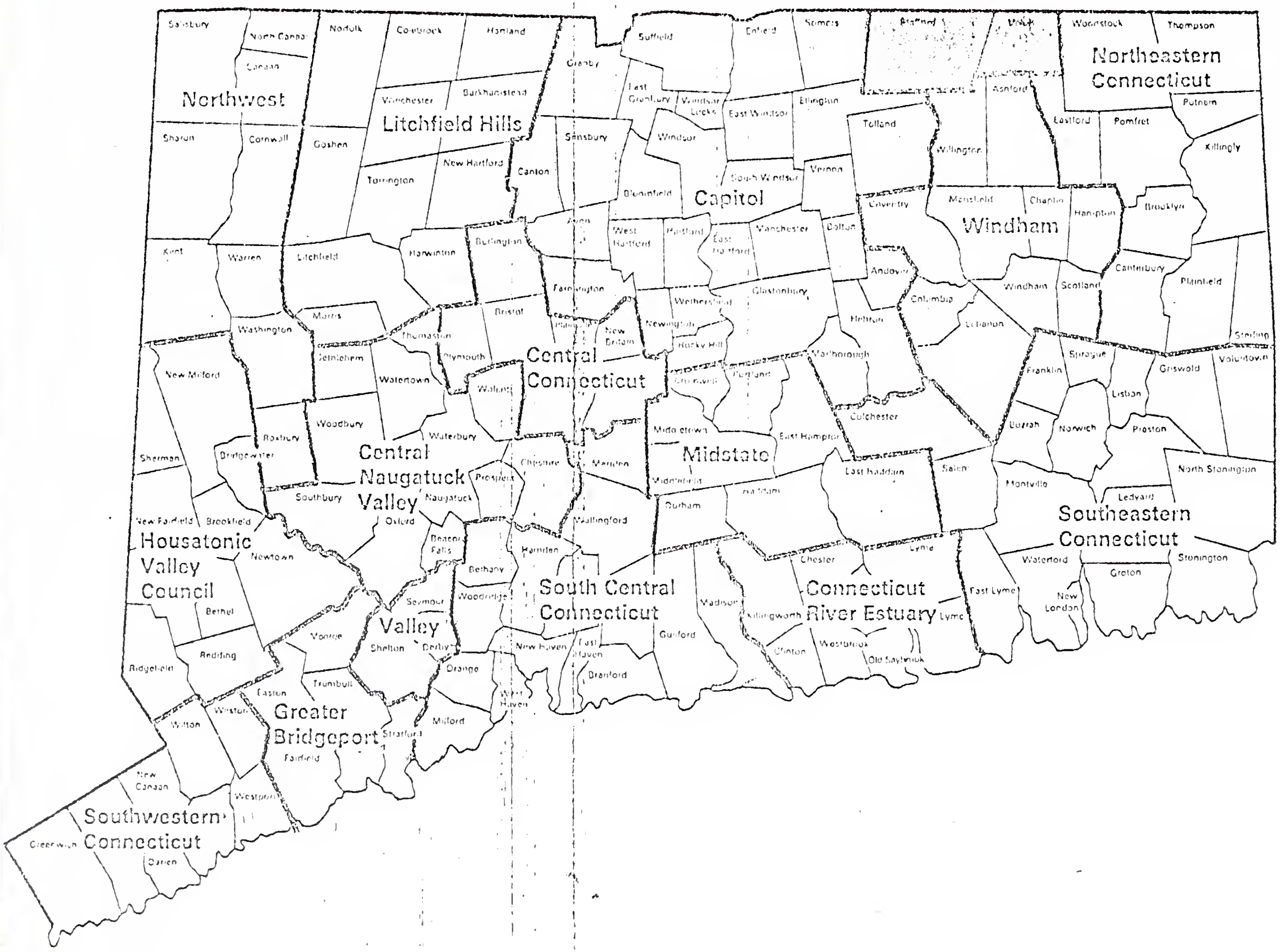
Source: Connecticut Commission on Hospitals
Health Care

The Project upon which this map is based was performed pursuant to contract no HSM 110-72 with the Health Services and Mental Health Administration, Department of Health, Educatio and Welfare.

New Haven Health Care, Inc.
1303 Chapel Street
New Haven CT 06511
2/75

Approx scale 1 in:15 mi

Regional Planning Areas of Connecticut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Capitol
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Windham
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Midstate
Southeastern Connecticut
Central Naugatuck Valley
Housatonic Valley Council
Valley
South Central Connecticut
Connecticut River Estuary
Greater Bridgeport
Southwestern Connecticut
Salisbury
North Canaan
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Norfolk
Colebrook
Hartland
Winchester
Barkhamsted
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Harwinton
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West Hartford
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Manchester
Bolton
Andover
Windham
Scotland
Canterbury
Plainfield
Farmington
Wethersfield
Glastonbury
Columbia
Lebanon
Hebron
Washington
Morris
Thomaston
Bristol
Plainville
New Britain
Newington
Rocky Hill
Cromwell
Portland
Marlborough
Sterling
Voluntown
Sprague
Franklin
Griswold
Lisbon
New Milford
Bethlehem
Plymouth
Watertown
Wolcott
Middletown
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Colchester
Bozrah
Norwich
Preston
Roxbury
Woodbury
Waterbury
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Bridgewater
Cheshire
Meriden
East Haddam
Salem
Montville
North Stonington
Ledyard
Prospect
Southbury
Naugatuck
Middlefield
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Durham
Wallingford
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Beacon Falls
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Monroe
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Clinton
Westbrook
Old Saybrook
Ridgefield
Redding
Trumbull
Orange
Branford
Easton
Weston
West Haven
Milford
Wilton
Stratford
Fairfield
New Canaan
Westport
Greenwich
Darien

▨ Not in any planning region

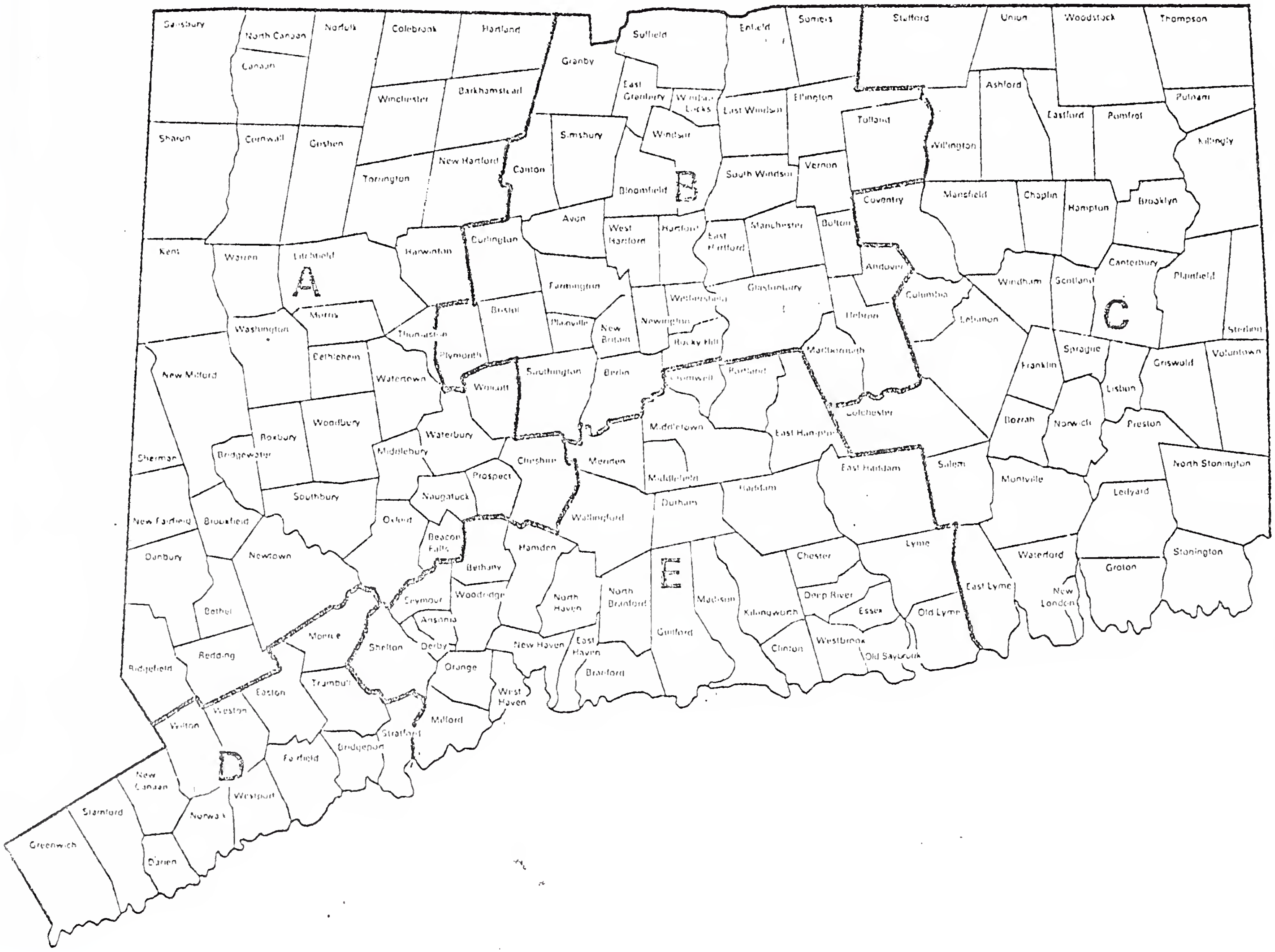
Source: Greater New Haven Chamber of Commerce: Economic Profile, South Central Connecticut 1973-74

The Project upon which this map is based was performed pursuant to contract no. HSM 110-72-37 with the Health Services and Mental Health Administration, Department of Health, Education and Welfare.

New Haven Health Care, Inc.
1303 Chapel Street
New Haven CT 06511
2/75
Approx scale 1 In:15 mi

Map 11

Council on Human Servic
Regions of Connecticut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Guilford
Old Lyme
Ridgefield
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Old Saybrook
Orange
Branford
Easton
Trumbull
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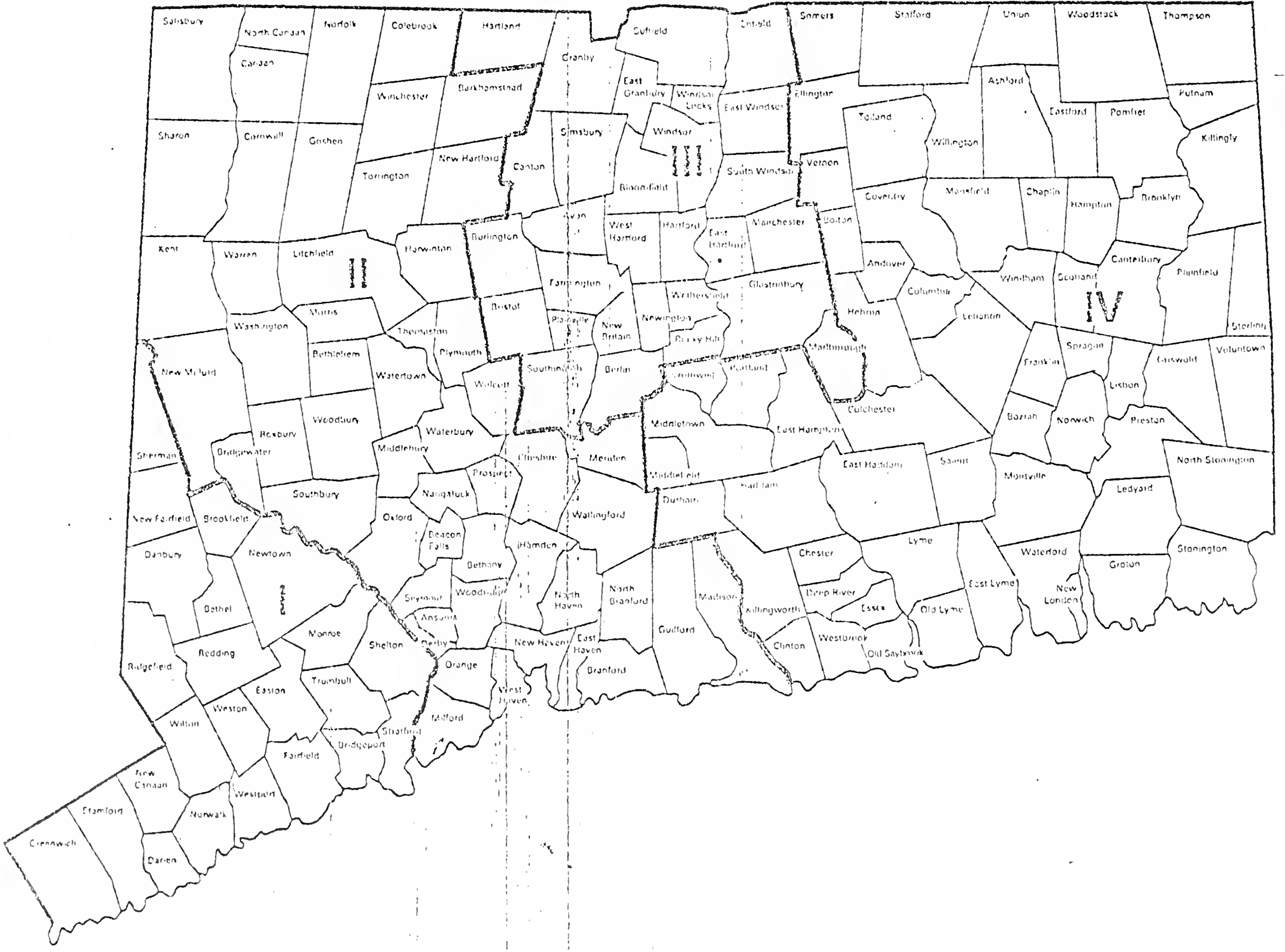
Wilton
Milford
Stratford
Bridgeport
Fairfield
New Canaan
Westport
Stamford
Norwalk
Greenwich
Darien

Source: Connecticut Council of Human Se
Report to the Governor and General Asse
January 1975

The Project upon which this map is based
performed pursuant to contract no HSM
with the Health Services and Mental Heal
Administration, Department of Health, Ed
and Welfare.

New Haven Health Care, Inc
1303 Chapel Street
New Haven CT 06511
2/75
Approx scale 1 in. 15 mi

PSRO regions of Connecticut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Bristol
Plainville
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Greenwich
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The Project upon which this map is based was performed pursuant to contract no. HSM 110-72- with the Health Services and Mental Health Administration, Department of Health, Education and Welfare.

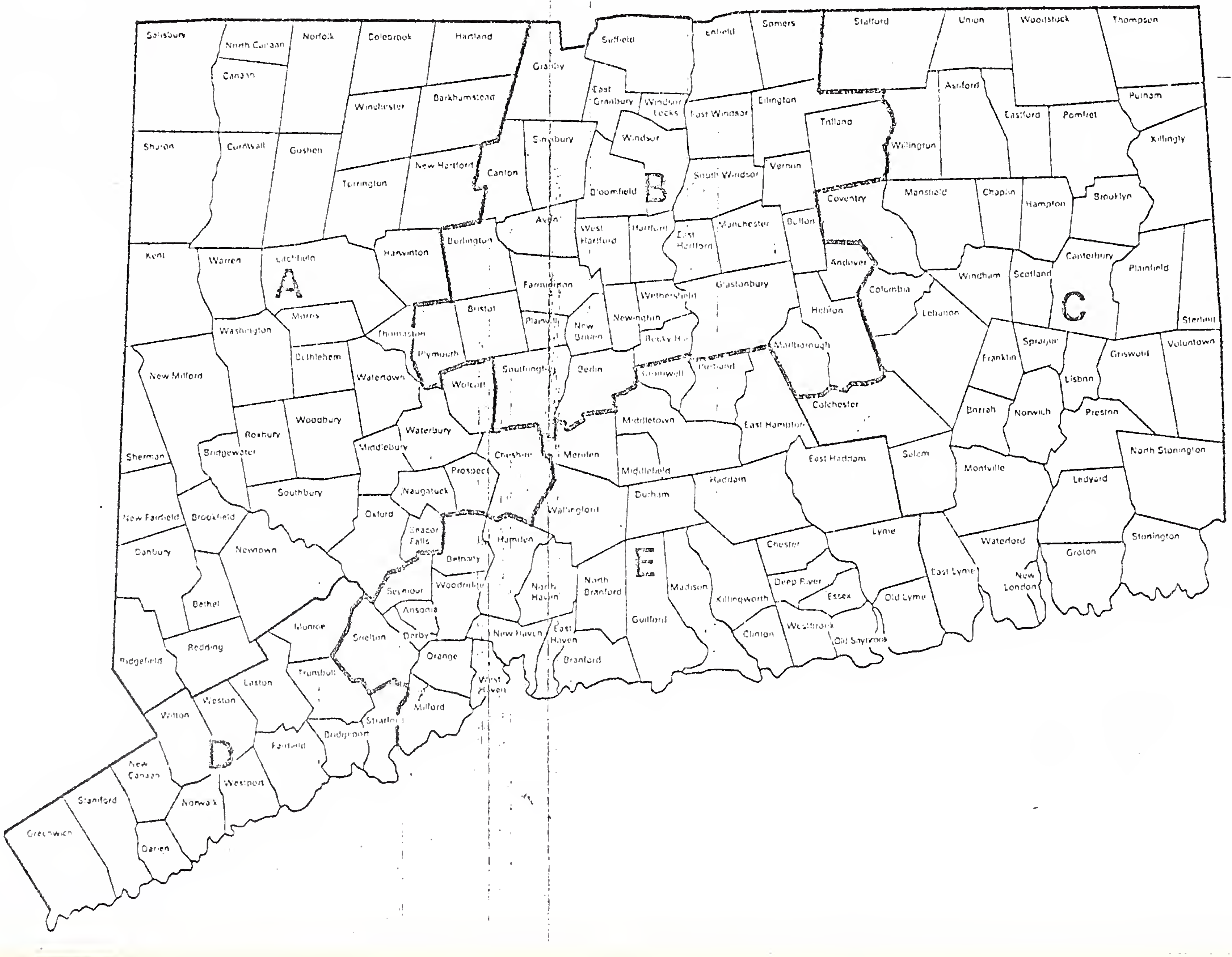
New Haven Health Care, Inc.
1303 Chapel Street
New Haven CT 06511
2/75
Approx scale 1 In.15 ml

Map 12

Three HSA's Based on CHS Regions Option 3

▬ HSA Boundaries

— Sub-Area Boundries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Barkhamstead
East Granbury
Windsor Locks
East Windsor
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Ashford
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Pomfret
Putnam
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Cornwall
Goshen
Torrington
New Hartford
Canton
Simsbury
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South Windsor
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Plainville
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Hebron
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Derby
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Guilford
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Old Saybrook
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Easton
West Haven
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Milford
Wilton
Stratford
Bridgeport
Fairfield
New Canaan
Westport
Stamford
Norwalk
Greenwich
Darien

The Project upon which this map is based
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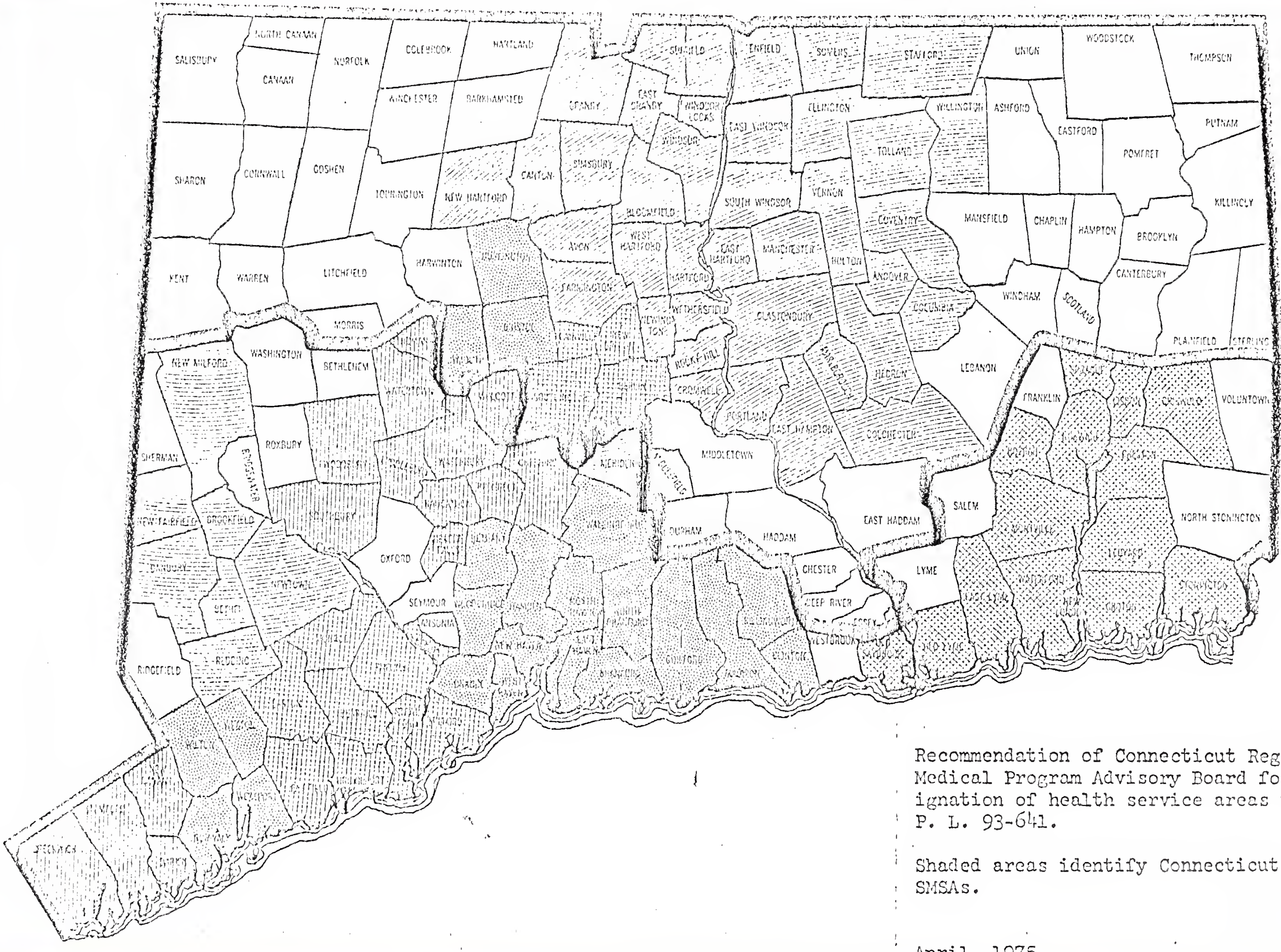
and Welfare.

New Haven Health Care, Inc.
1303 Chapel Street
New Haven CT 06511
2/75
Approx scale 1 in: 15 mi

Map 13

Map 14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WINCHESTER
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GRANBY
EAST GRANBY
SUFFIELD
WINDSOR LOCKS
ENFIELD
SOMERS
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UNION
WOODSTOCK
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NEW HARTFORD
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TOLLAND
WILLINGTON
ASHFORD
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PUTNAM
POMFRET
KILLINGLY
SOUTH WINDSOR
VERNON
BLOOMFIELD
WEST HARTFORD
AVON
EAST HARTFORD
MANCHESTER
BOLTON
COVENTRY
MANSFIELD
CHAPLIN
HAMPTON
BROOKLYN
KENT
WARREN
LITCHFIELD
HARWINTON
FARMINGTON
HARTFORD
ANDOVER
CANTERBURY
WINDHAM
SCOTLAND
WETHERSFIELD
NEWINGTON
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NEW MILFORD
WASHINGTON
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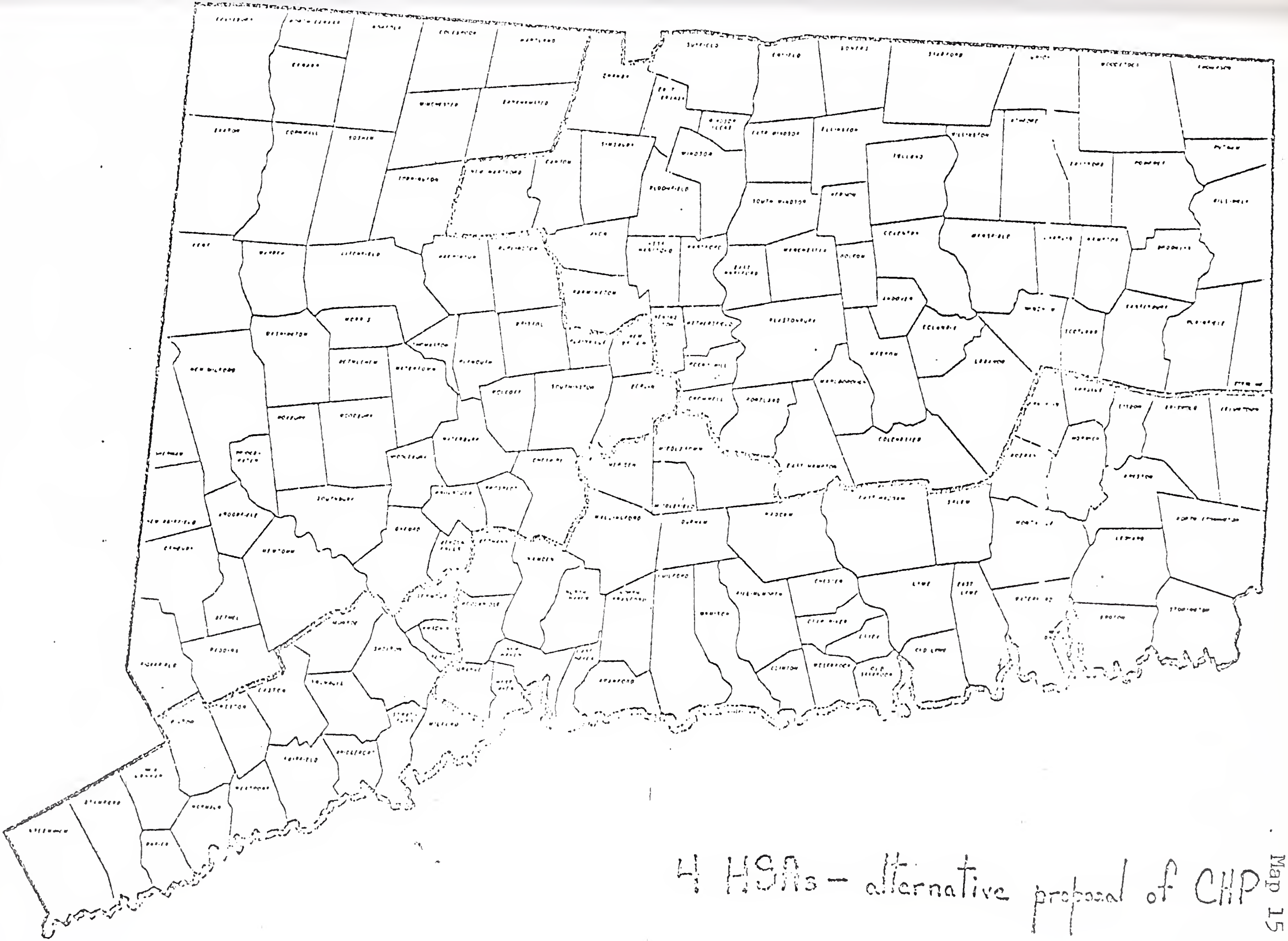
WATERTOWN
WOLCOTT
ROCKY HILL
CROMWELL
HEBRON
LEBANON
FRANKLIN
VOLUNTOWN
PORTLAND
EAST HAMPTON
COLCHESTER
ROXBURY
SHERMAN
BRIDGEWATER
MERIDEN
MIDDLETOWN
MIDDLEFIELD
SALEM
NORTH STONINGTON
NEW FAIRFIELD
BROOKFIELD
EAST HADDAM
DURHAM
HADDAM
OXFORD
DANBURY
NEWTOWN
CHESTER
LYME
BETHEL
SEYMOUR
DEEP RIVER
ESSEX
ANSONIA
NEW HAVEN
WESTBROOK
RIDGEFIELD
REDDING
GUILFORD
MONTVILLE
WATERFORD
NEW LONDON
GROTON
LEDYARD
STONINGTON
OLD LYME
CLINTON
WILTON
WESTPORT
GREENWICH

Recommendation of Connecticut Regional Medical Program Advisory Board for designation of health service areas under P. L. 93-641.

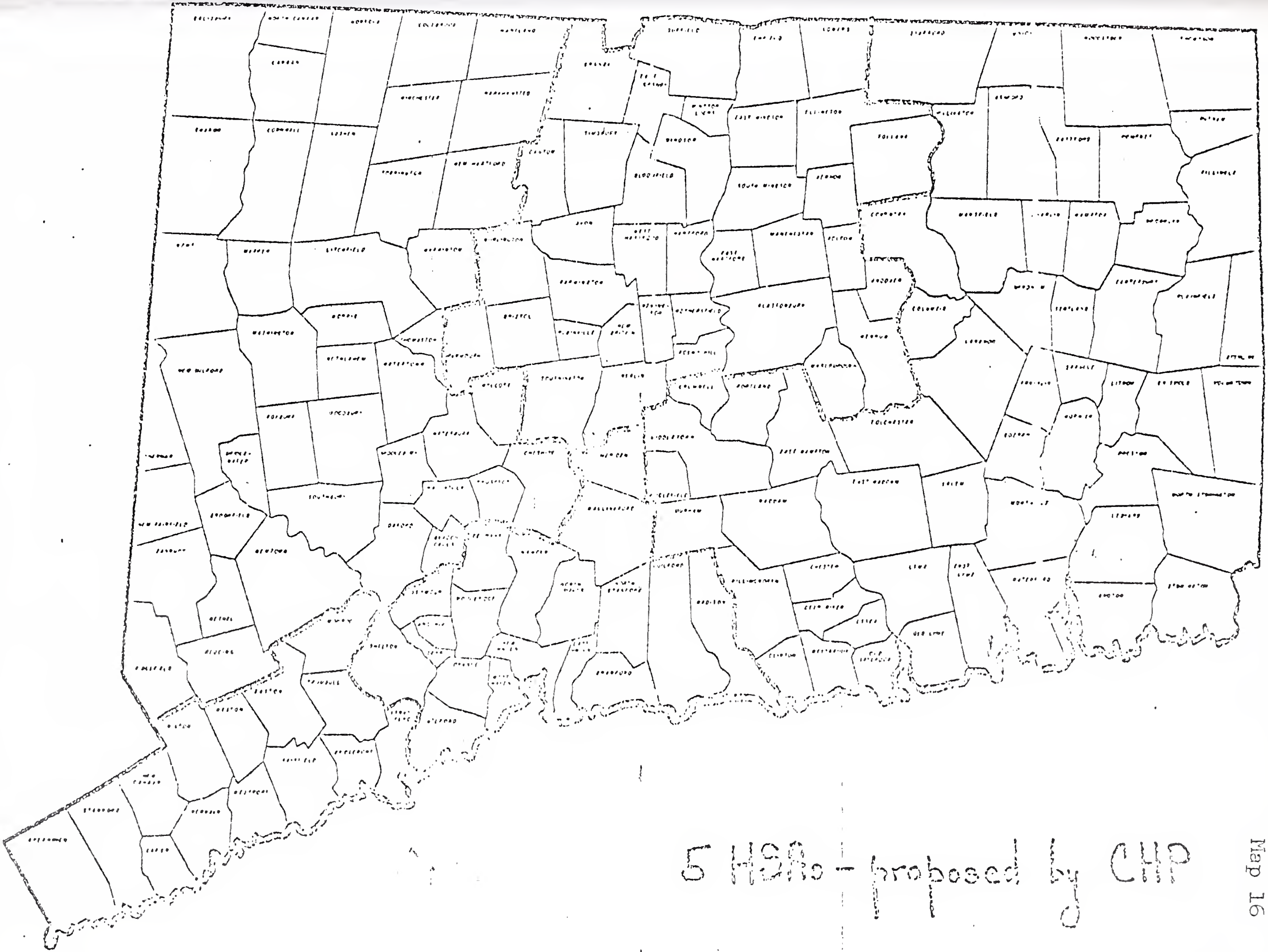
Shaded areas identify Connecticut's 11 SMSAs.

April, 1975

Map 15



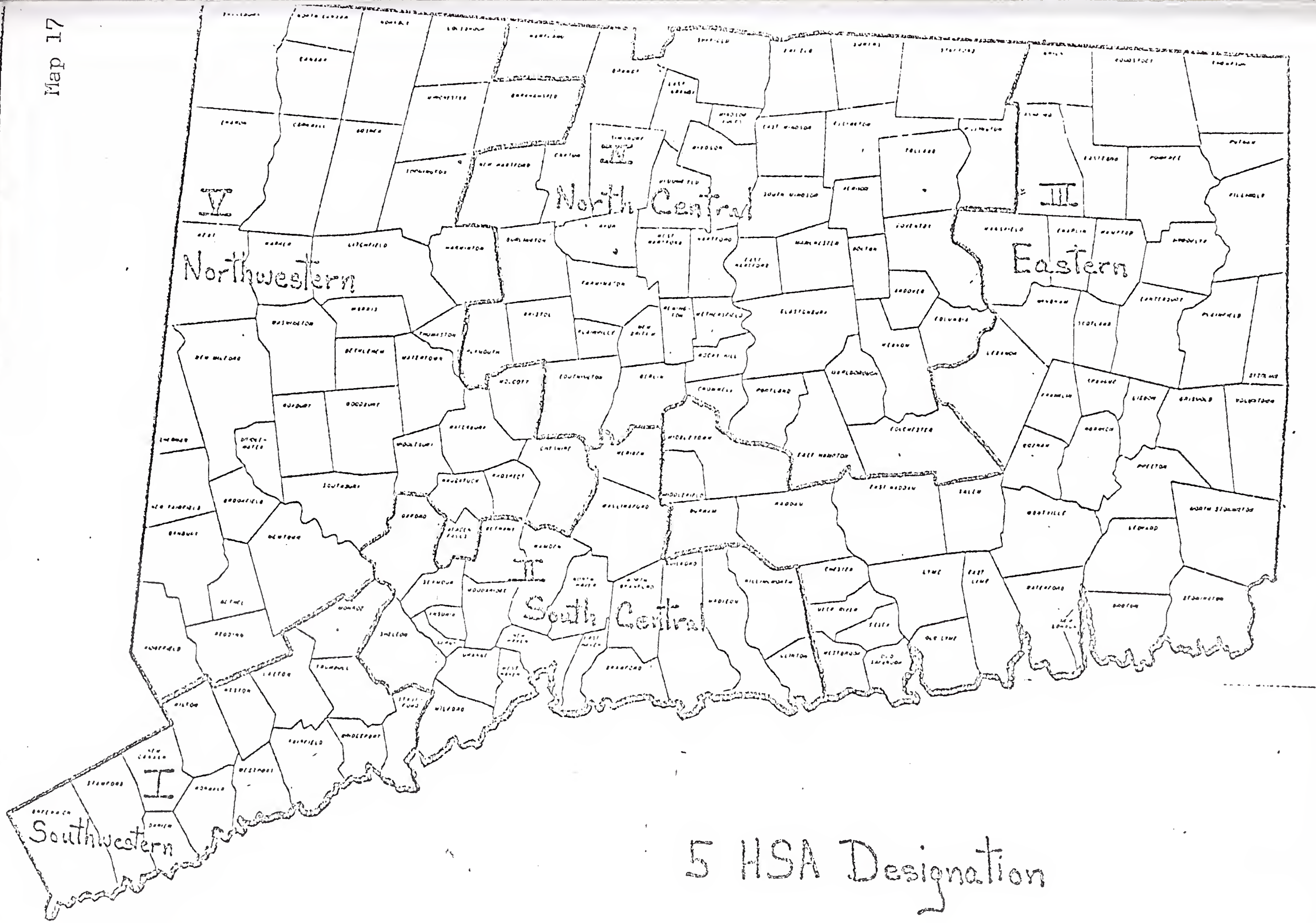
4 HSAs - alternative proposal of CHP



5 HSAs – proposed by CHP

Map 16

Map 17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IV
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Eastern
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South Central
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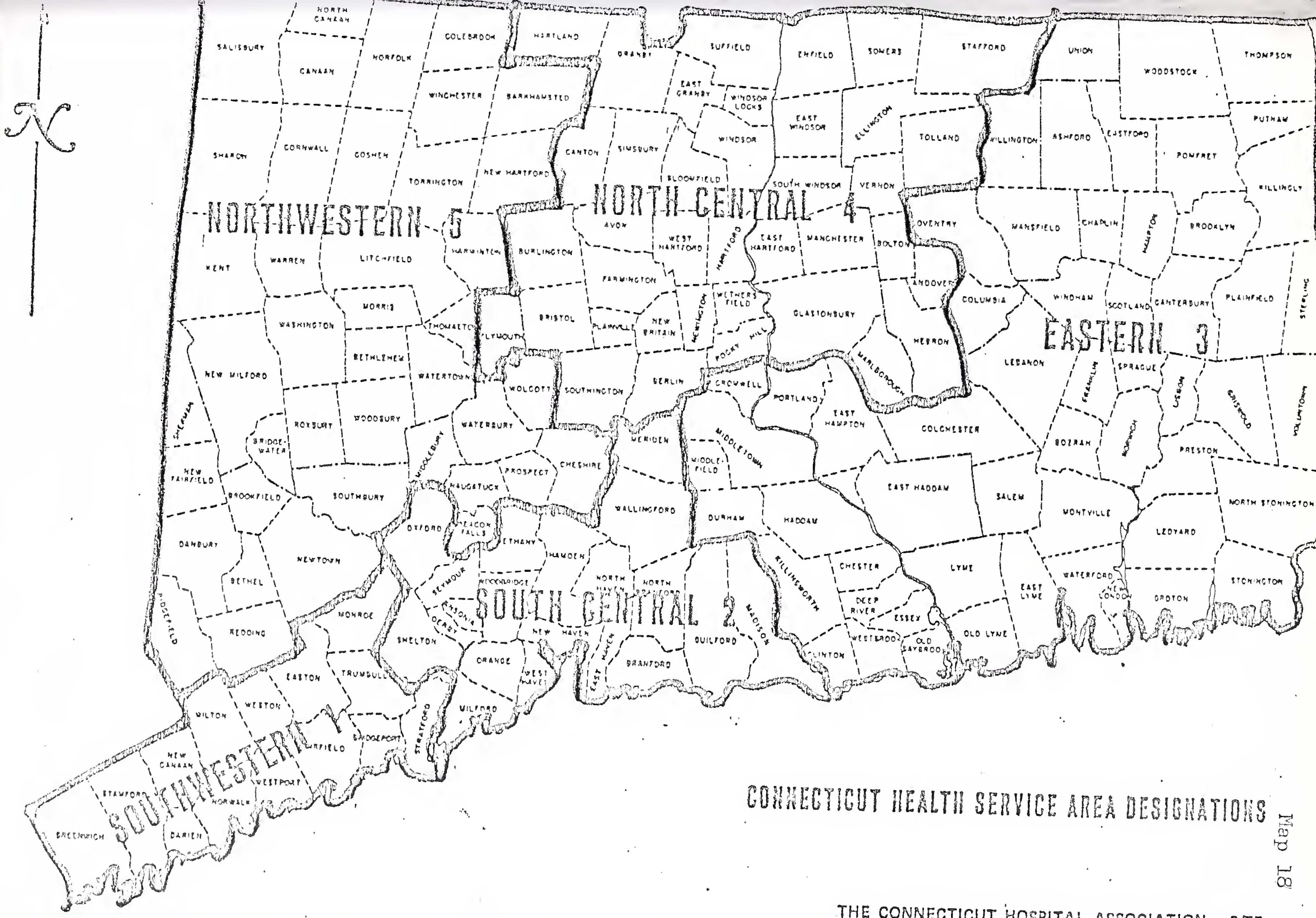
Southwestern

5 HSA Designation


NORTHWESTERN 5
NORTH CENTRAL 4
EASTERN 3
SOUTH CENTRAL 2
SOUTHWESTERN 1
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COLEBROOK
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HAMPTON
BROOKLYN
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NAUGATUCK
PROSPECT
CHESHIRE
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GROTON
RIDGEFIELD
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SEYMOUR
WOODBRIDGE
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DERBY
NORTH HAVEN
NORTH BRANFORD
KILLINGWORTH
DEEP RIVER
ESSEX
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OLD LYME
REDDING
MONROE
SHELTON
NEW HAVEN
MADISON
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WESTBROOK
OLD SAYBROOK
CLINTON
EASTON
TRUMBULL
ORANGE
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FAIRFIELD
BRIDGEPORT
NEW CANAAN
WESTPORT
STAMFORD
NORWALK
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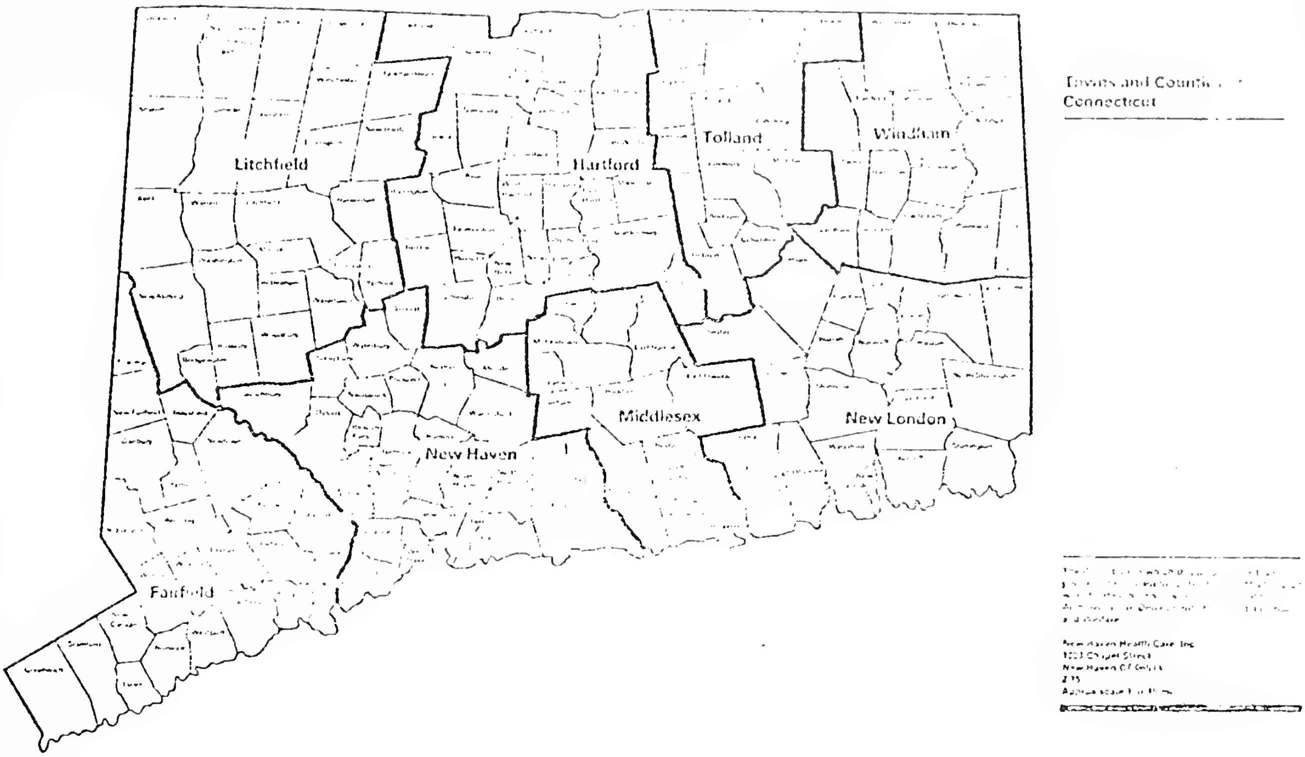
CONNECTICUT HEALTH SERVICE AREA DESIGNATIONS

Map 18

THE CONNECTICUT HOSPITAL ASSOCIATION 8/75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Hartford
Tolland
Windham
Fairfield
New Haven
Middlesex
New London
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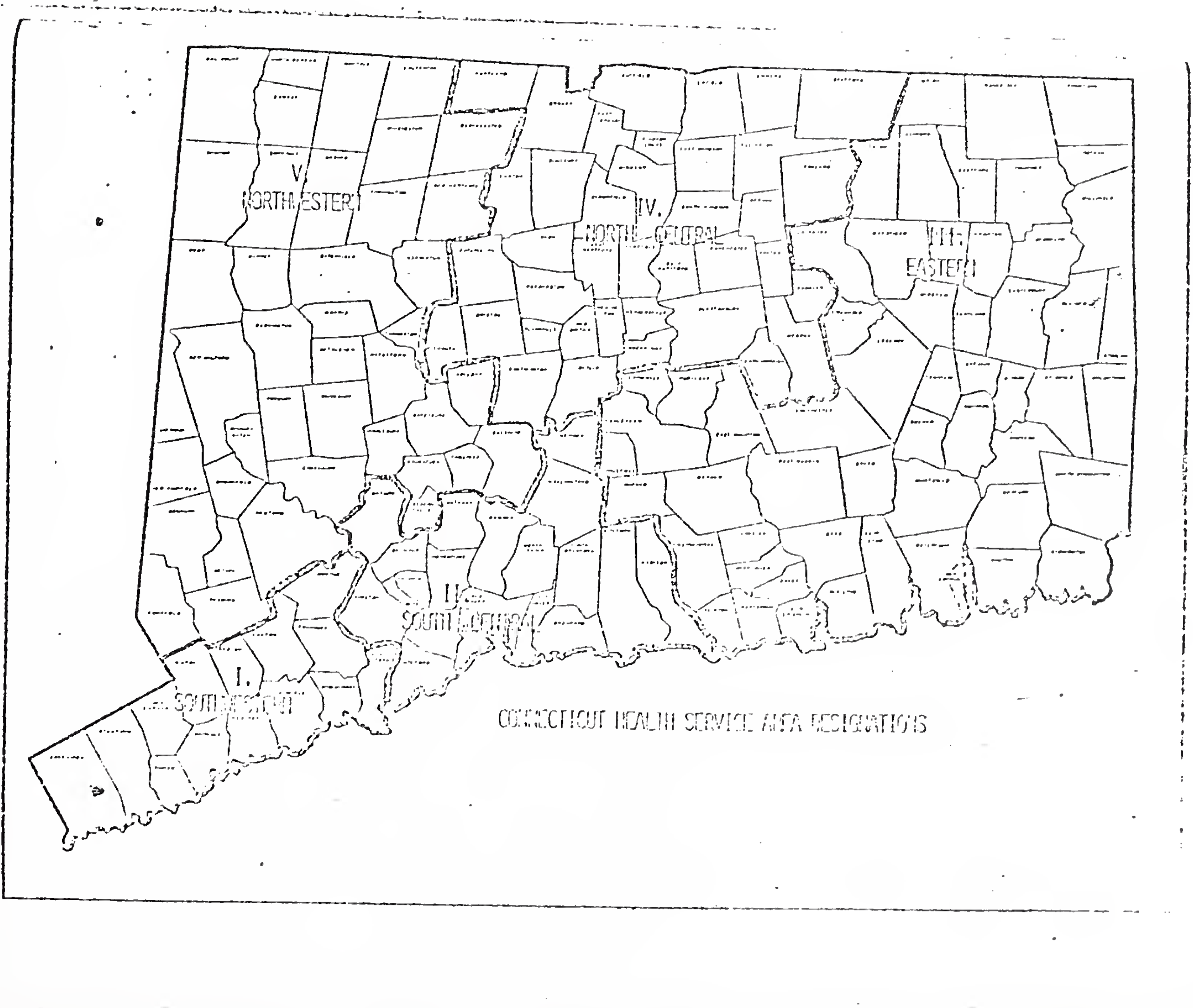
1003 Chapel Street
New Haven CT 06511
Approx scale 1 in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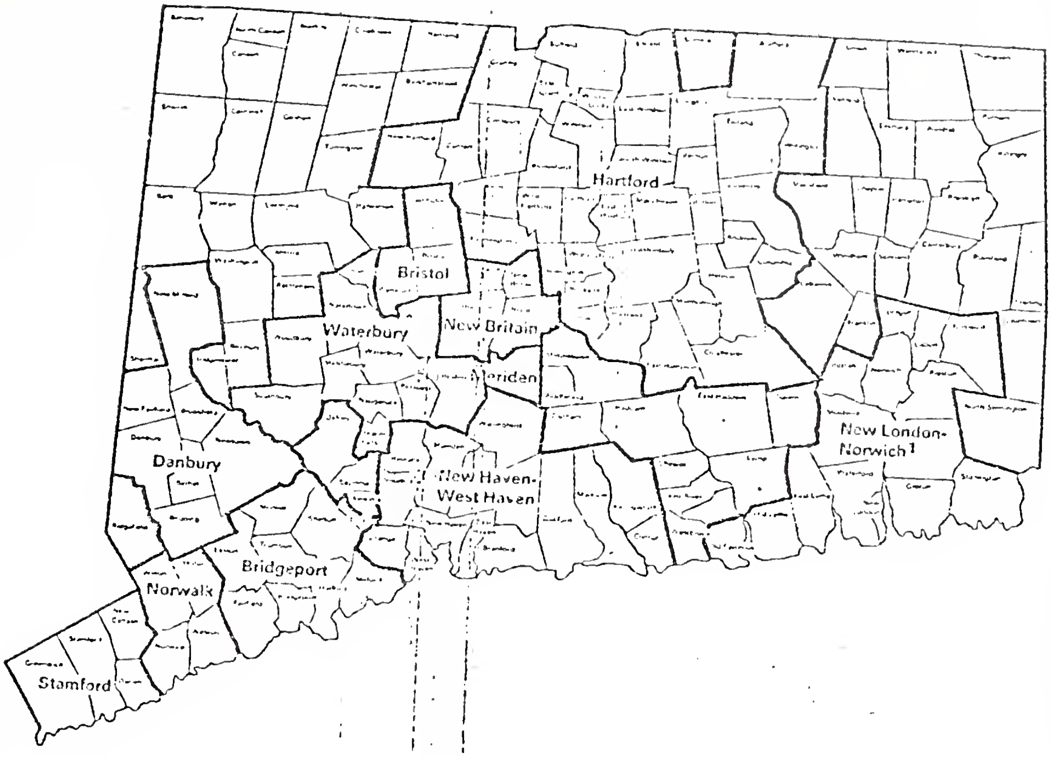
III. EASTERN
II. SOUTH CENTRAL
I. SOUTHWESTERN

CONNECTICUT HEALTH SERVICE AREA DESIGNATIONS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Bristol
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Meriden
New London-
Norwich[1]
Danbury
New Haven-
West Haven
Bridgeport
Norwalk
Stamford

Standard Metropolitan Statistical Areas of Connecticut

Area not in SMSA

Part of Springfield, Mass. SMSA

[1] Includes Hopkinton, Westerly, R.I.

Source: U.S. Dept of Commerce National Bureau of Standards, FIPS Publication 8-4
6-20-74

The Project upon which this map is based was performed pursuant to contract [illegible] 72 377 with the Health Services and Mental Health Administration, Department of Health, Education and Welfare

New Haven Health Care, Inc.
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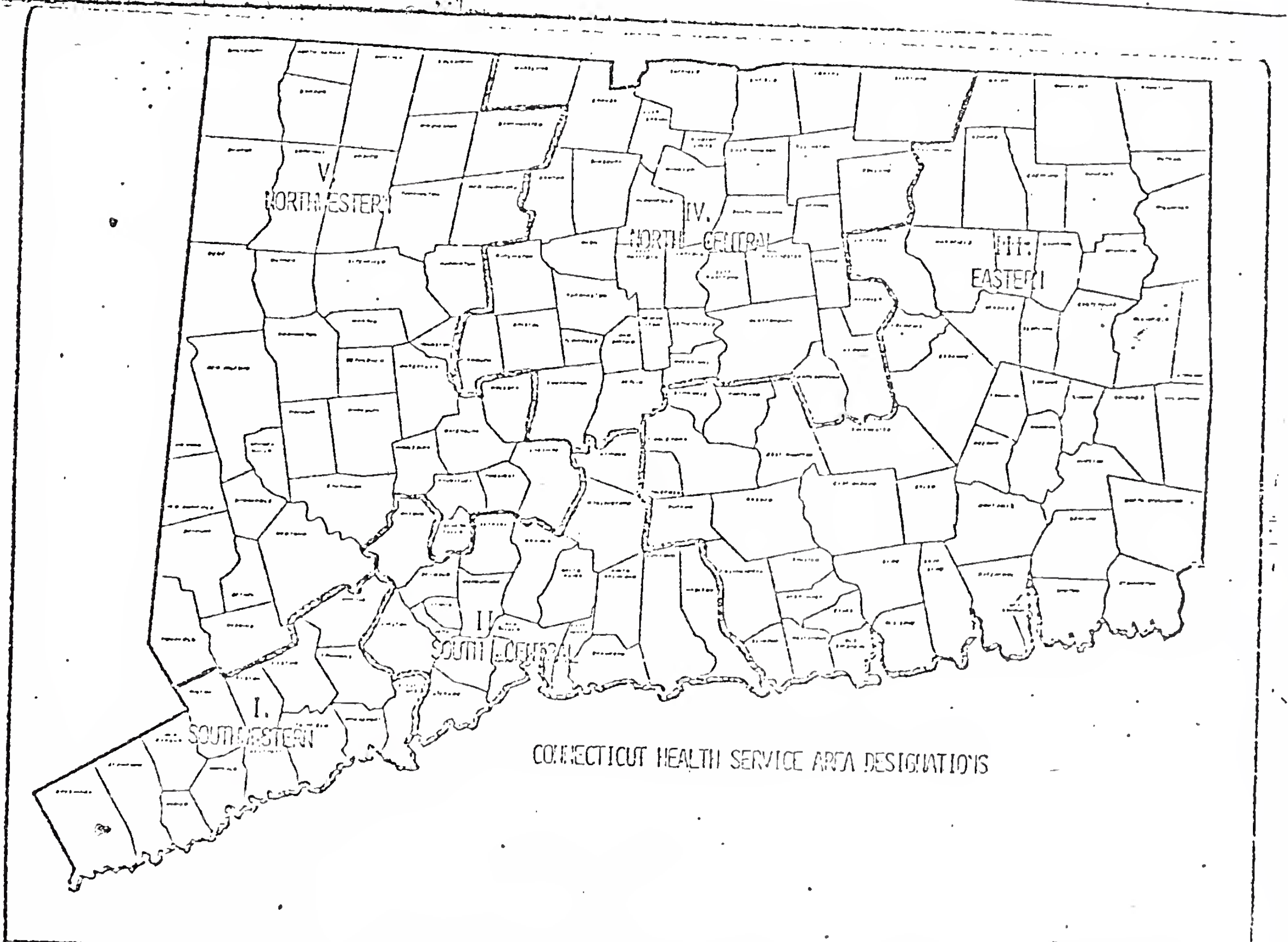
New Haven CT 06511
2/75
Approx scale 1 in. 15 mi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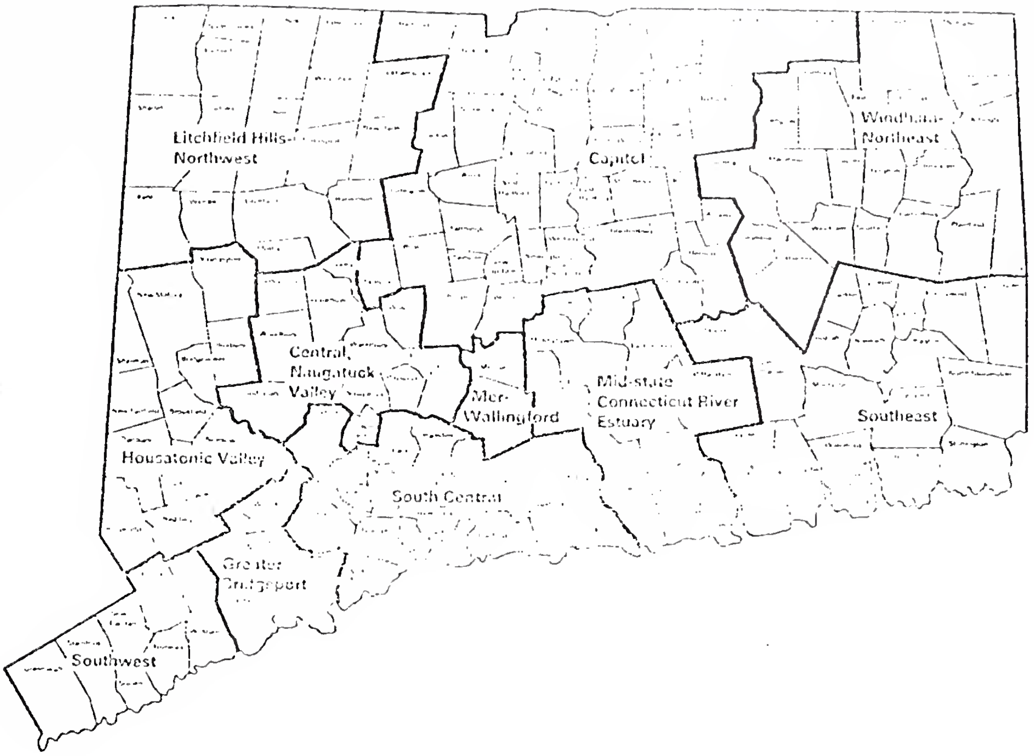
SOUTH CENTRAL
I.
SOUTHWESTERN

CONNECTICUT HEALTH SERVICE AREA DESIGNATIONS

Map 21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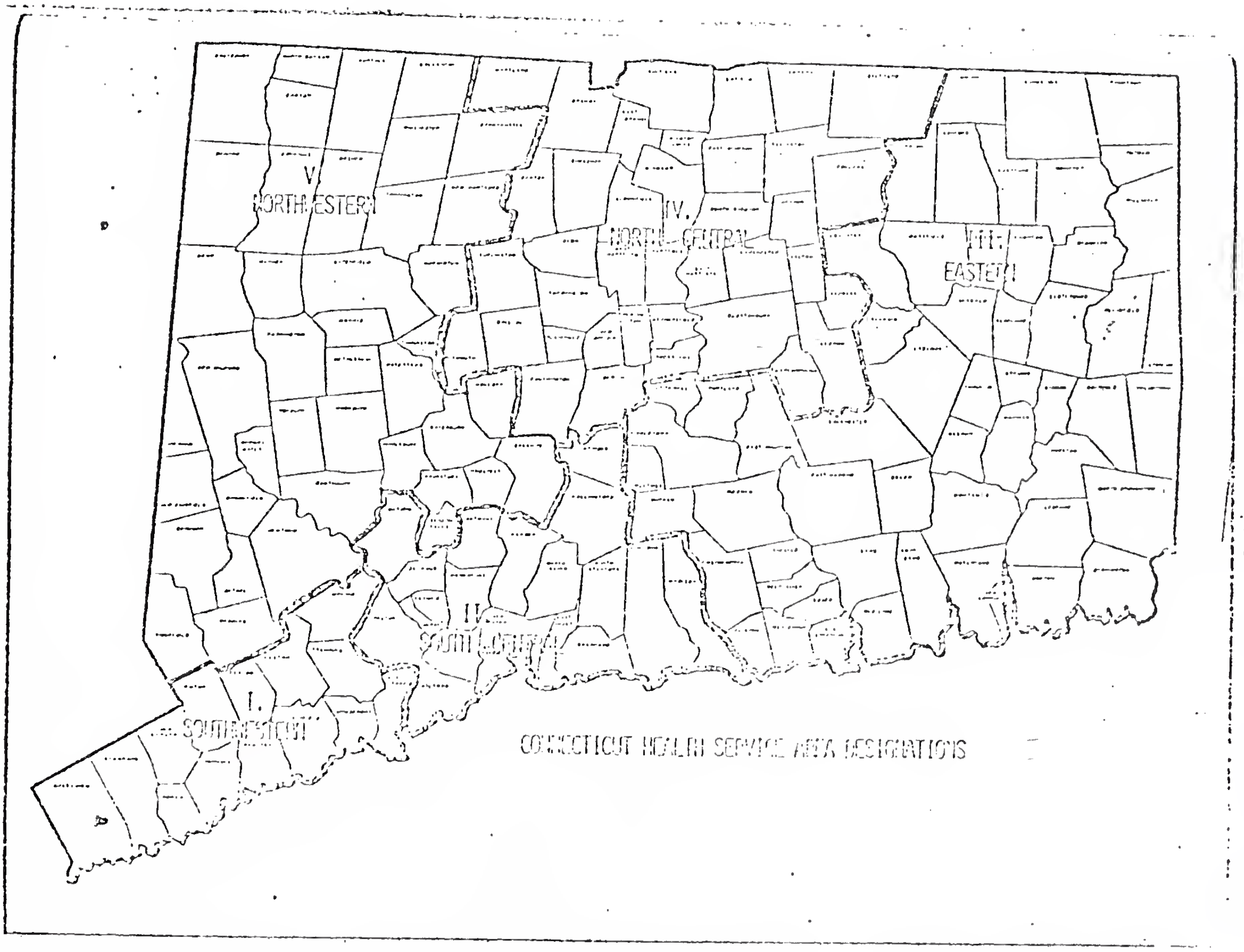
Capitol
Windham-Northeast
Central Naugatuck Valley
Meriden-Wallingford
Mid-state Connecticut River Estuary
Southeast
Housatonic Valley
South Central
Greater Bridgeport
Southwest

Comprehensive Health Planning Regions of Connecticut

Source: Connecticut Commission on Hospitals and Health Care

New Haven Health Care, Inc.
New Haven CT 06511
Approximate scale 1 in 15 mi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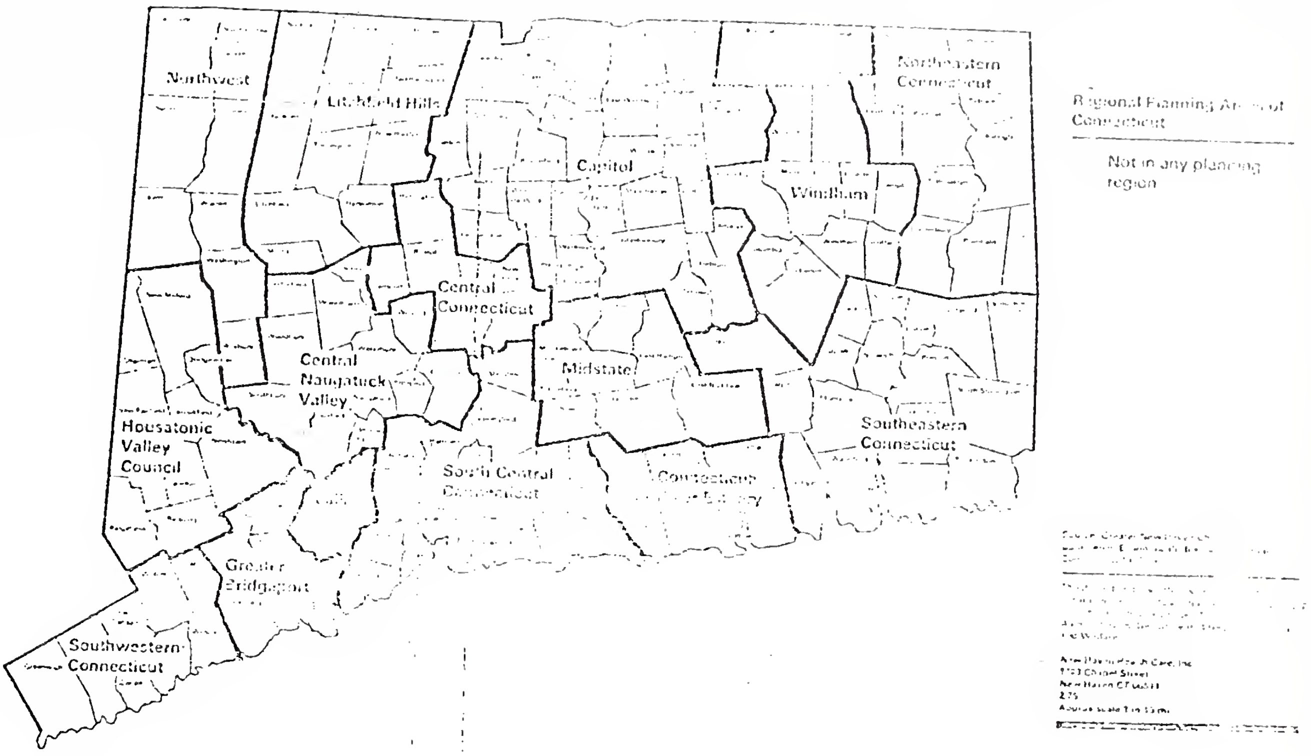
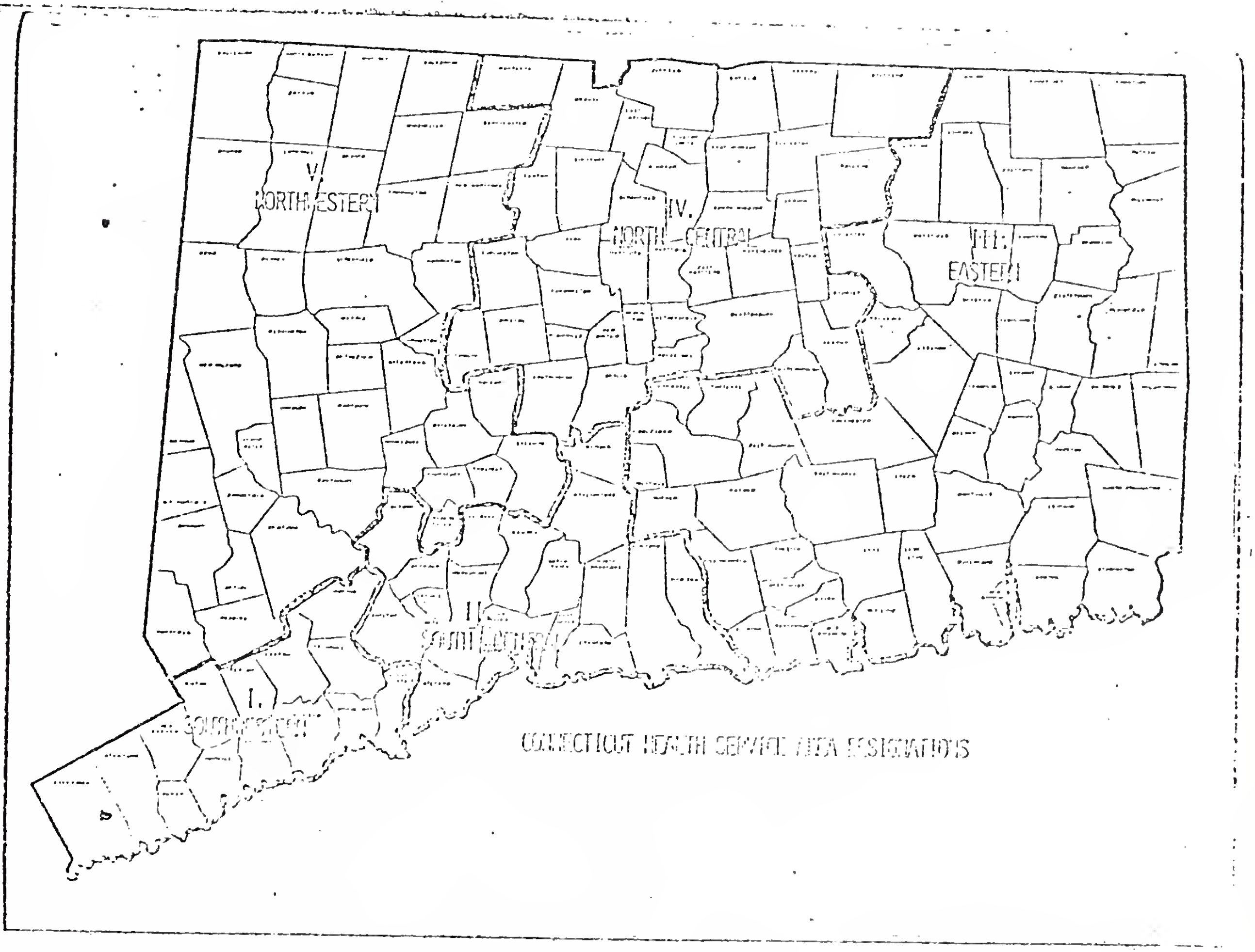
I. SOUTHWESTERN

CONNECTICUT HEALTH SERVICE AREA DESIGNATIONS


Northwest
Litchfield Hills
Capitol
Northeastern Connecticut
Windham
Central Connecticut
Central Naugatuck Valley
Midstate
Southeastern Connecticut
Housatonic Valley Council
South Central Connecticut
Connecticut River Estuary
Greater Bridgeport
Southwestern Connecticut
Not in any planning region
New Haven Health Care, Inc
Chapel Street
New Haven CT

Regional Planning Areas of Connecticut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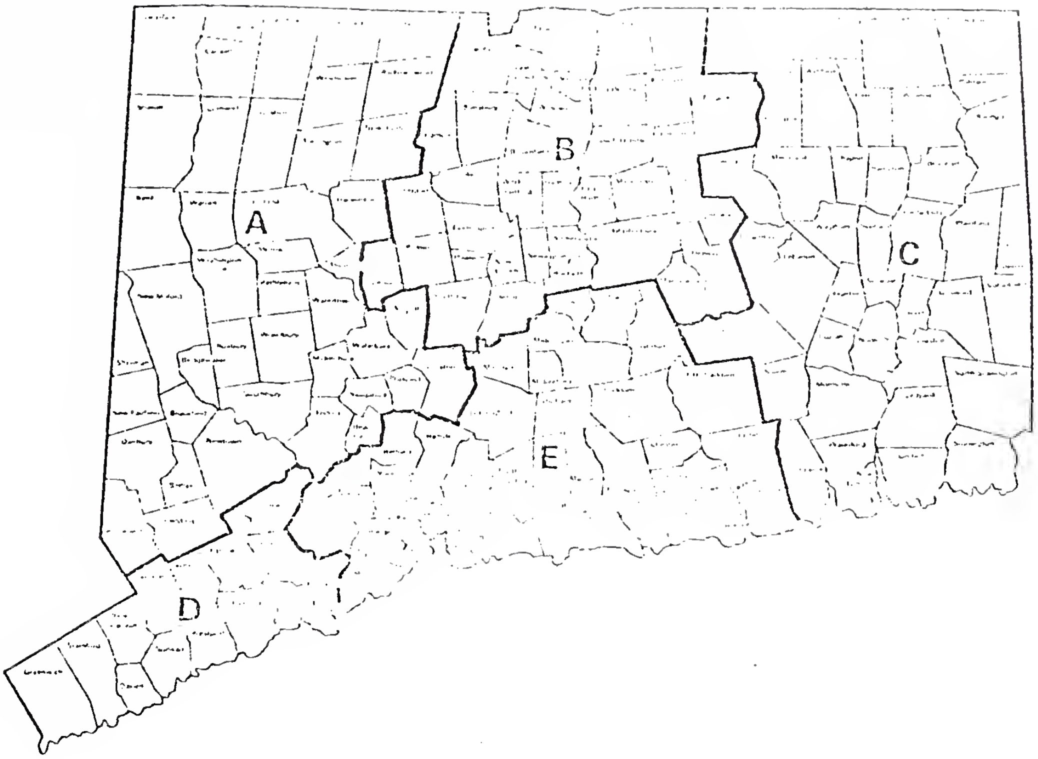
I. SOUTHWESTERN

CONNECTICUT HEALTH SERVICE AREA DESIGNATIONS



Council on Human Services
Regions of Connecticut

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New Haven Health Care Inc
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New Haven CT 06511
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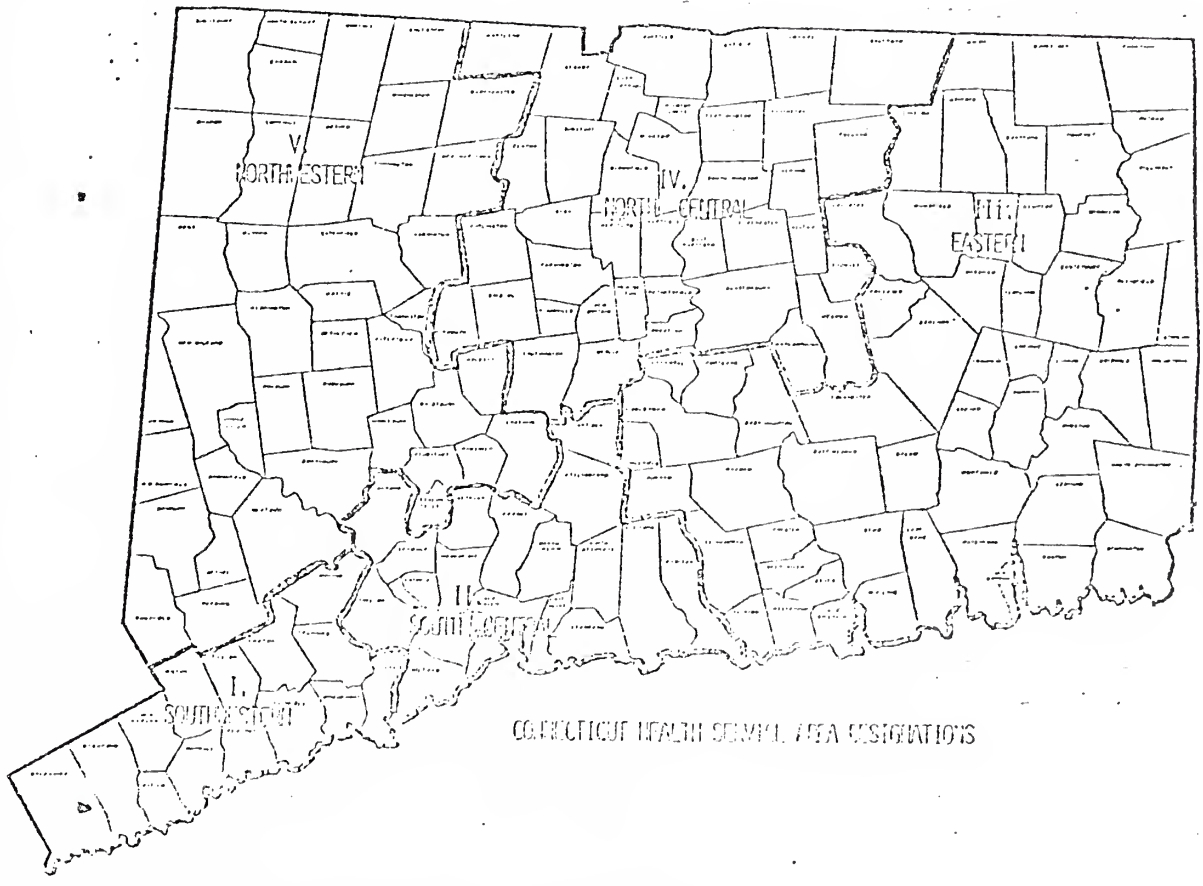
Approx scale 1 in 15 mi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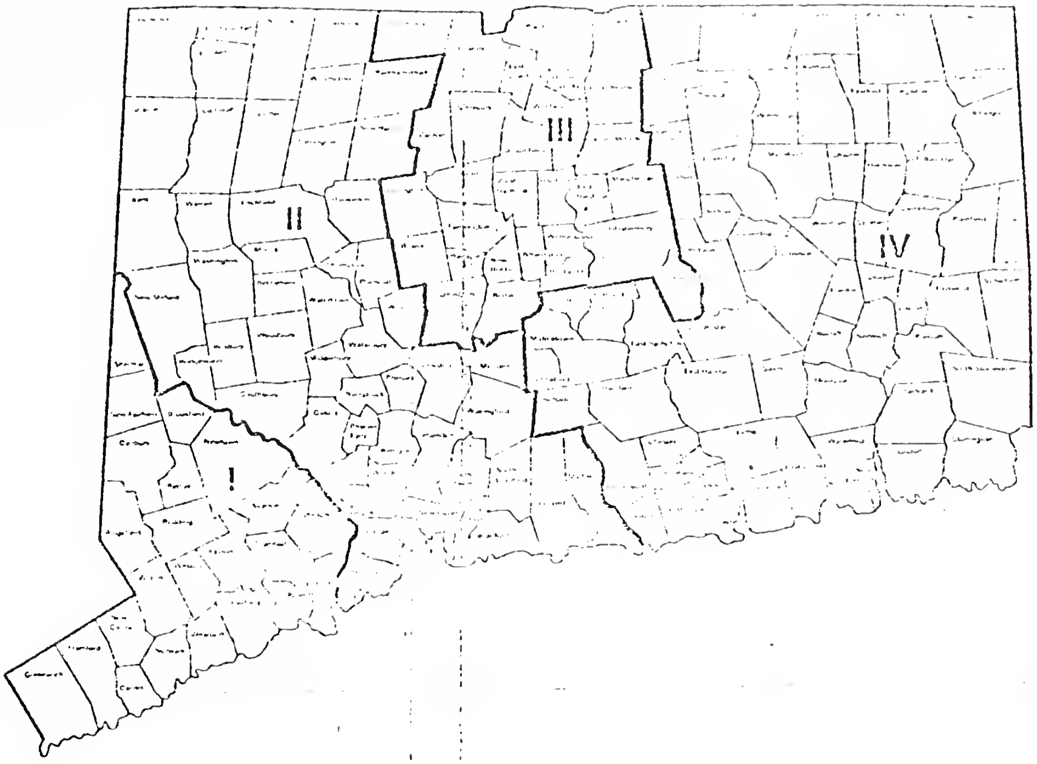
SOUTHWESTERN

CONNECTICUT HEALTH SERVICE AREA DESIGNATIONS



PSRO regions of Connecticut

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New Haven Health Care, Inc
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New Haven CT 06511
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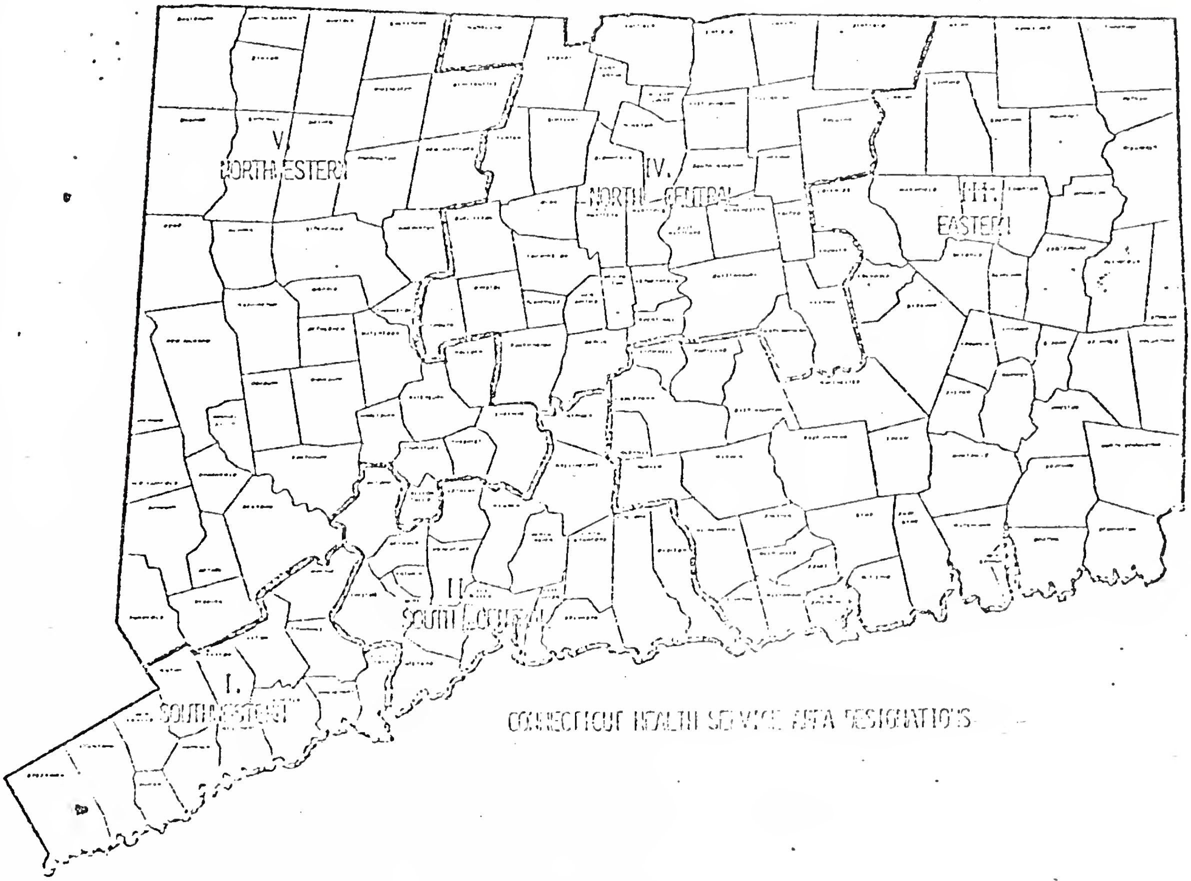
Approx scale 1 in 15 mi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III. EASTERN
II. SOUTH CENTRAL
I. SOUTHWESTERN

CONNECTICUT HEALTH SERVICE AREA DESIGNATIONS

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